

**REPORT OF THE
JOINT LEGISLATIVE AUDIT
AND REVIEW COMMISSION**

**REVIEW OF THE
COMPREHENSIVE
SERVICES ACT**

**TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA**



SENATE DOCUMENT NO. 26

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Ex Officio, Auditor of Public Accounts

MR. PHILIP A. LEONE
Director

Preface

Through Virginia's Comprehensive Services Act (CSA), the 1992 General Assembly established one of the nation's first comprehensive systems of care for at-risk children. The system was put in place to provide treatment services for children who exhibit serious emotional and behavioral problems.

Senate Joint Resolutions 123 (1996) and 371 (1997), as well as language in the 1997 Appropriation Act, required the Joint Legislative Audit and Review Commission (JLARC) to assess CSA's implementation. This report provides findings from that review. As a part of the study, JLARC staff reviewed more than 1,100 files of youths participating in CSA, in order to obtain the data necessary for a detailed analysis of how the program is operating.

The study found that localities have experienced some success with CSA, which has provided a mechanism, although not fully used, for involving agencies at the local level in a collaborative process for making service decisions. Consistent with the intent of CSA, localities are serving CSA children in least restrictive and less expensive environments. Further, once children leave the program, their behavioral problems appear to be stabilizing.

However, to ensure a more efficient delivery of services, both the State and localities will need to address a number of problems with program implementation, including inconsistent use of collaborative planning at the local level, inadequate client assessments, insufficient attention to provider fees, and limited program oversight and monitoring. If not properly addressed, these problems could undermine CSA in the long term. This report makes recommendations to address these problems.

It should be noted that one approach to both increasing CSA program accountability and achieving State and local cost savings would be to use Medicaid as an alternative funding source for CSA. JLARC staff estimate that more than \$41 million of the annual costs of CSA could be appropriately paid for by Medicaid, if the State implements such a policy. Of these annual savings, approximately 62.7 percent are estimated State savings, and approximately 37.3 percent are estimated local savings (based on the current average CSA State-local match rate).

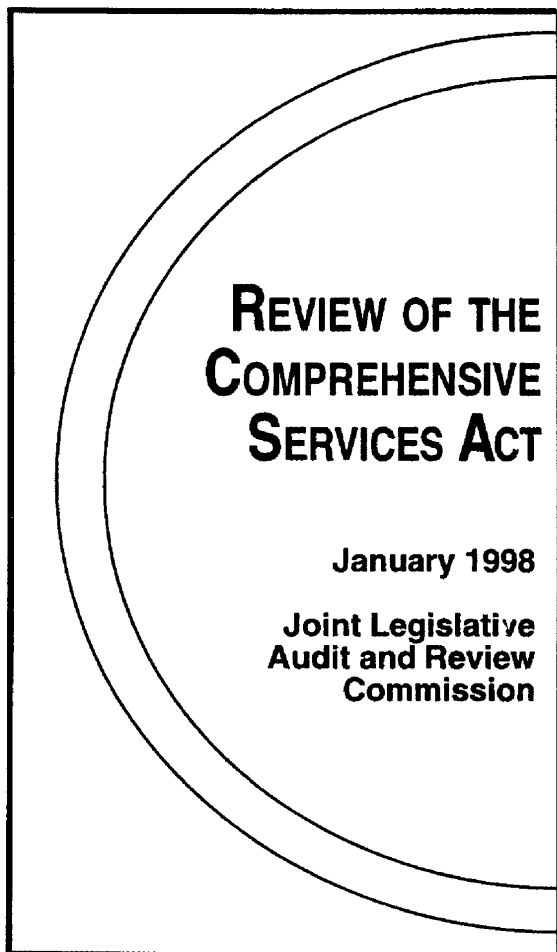
On behalf of the JLARC staff, I wish to express our appreciation for the assistance and cooperation provided by the Office of Comprehensive Services, local CSA personnel in the 22 localities examined in detail for this review, and also CSA coordinators and others involved in the CSA process at the local level.



Philip A. Leone
Director

January 7, 1998

JLARC Report Summary



In 1992, the Virginia General Assembly passed the Comprehensive Services Act (CSA) which established one of the nation's first comprehensive systems of care for at-risk children. This system was put in place to provide treatment services for the growing number of children who exhibit serious emotional and behavioral problems.

The passage of CSA was prompted by numerous problems which plagued the previous system that provided services for at-risk children. Among these problems were a fragmented service delivery system which fostered duplication in the provision of treatment services, and a funding structure which created local incentives to arrange for coun-

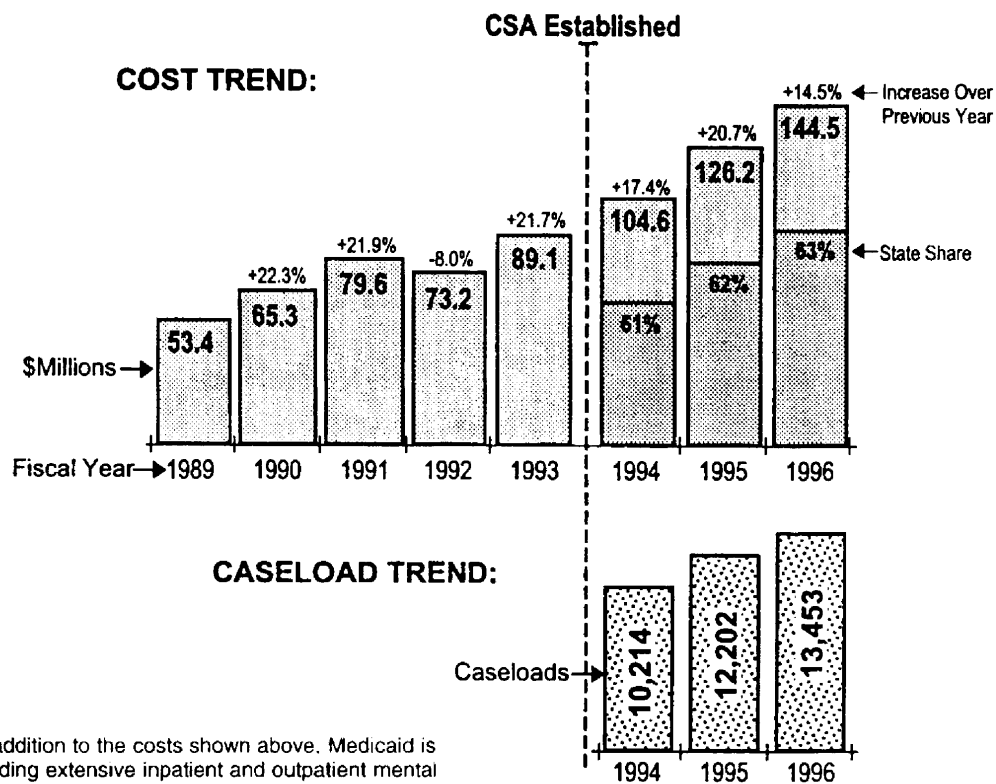
seling and related services in the most restrictive and expensive settings.

Through CSA, the General Assembly sought to correct these problems in three ways. First, resources from the multiple funding streams that supported the previous system were combined into one pool of funds. Second, local agencies that are responsible for the provision of services to at-risk children were encouraged to form collaborative arrangements and use the pooled funds to deliver non-duplicative services in the least restrictive settings possible. Finally, to ensure that local CSA programming would not be constrained by State regulations, the General Assembly organized the State structure and leadership for the program with a council of State officials rather than a single agency; gave many of the program oversight responsibilities to local officials; and provided local jurisdictions with the flexibility believed needed to develop and implement service plans for at-risk children.

In 1996, the General Assembly passed the first of two study resolutions directing JLARC to conduct a comprehensive review of this new program. The impetus for these resolutions grew from concerns regarding the trends in both CSA caseloads and total costs (see figure on next page). In its first three years of implementation, the growth in the total cost of CSA was comparable to the rates of growth observed under the previous system. Since CSA was expected to slow the costs of serving at-risk children with its emphasis on service collaboration and community-based care, numerous questions are now being raised about whether localities are implementing the program in a manner that is cost-effective and consistent with legislative intent.

Despite these concerns, policy proposals aimed at slowing the growth of CSA have

Cost and Caseload Trends for the Comprehensive Services Act



been tabled pending a systematic review of the program. This study provides such a review. With data collected from the program files of more than 1,100 CSA participants, detailed cost information, survey data, and information from structured interviews with State and local officials, JLARC staff examined the State and local implementation of this program.

The evidence from this study indicates that localities have experienced some successes with CSA but have encountered problems as well. Although it is not fully utilized, CSA has provided a mechanism for involving agencies at the local level in a collaborative process for making service decisions in a non-duplicative manner. Consistent with the intent of CSA, local governments are serving most CSA children in the least restrictive and less expensive environ-

ments. Further, once children leave the program, their behavioral problems appear to be stabilizing.

However, to ensure a more efficient delivery of services through CSA, both the State and localities will need to address a number of problems with the way the program is implemented. If not properly addressed, these problems — which include the failure to consistently use collaborative planning, inadequate client assessments, inattention to provider fees, and limited program oversight and monitoring — could undermine CSA in the long-term.

Some of the specific findings of the report are summarized as follows:

- While the methods used by localities to implement CSA have some impact on the size of the program's

caseloads, the primary factor responsible for the expansion of CSA is the growth in the State's at-risk population. Similarly, much of the local variation that exists in the costs of serving a given participant in the program can be explained by the level of dysfunction present in the child. As these factors are beyond the control of most localities, achieving savings in the aggregate cost of the program will be difficult without making policy decisions to limit the number of children who are eligible for CSA services.

- There are opportunities to improve both the efficiency of the program and the degree to which CSA meets legislative intent. Despite the emphasis the statute places on serving children with serious emotional and behavioral problems, almost half of the at-risk children who received treatment services through CSA in FY 1995 either had no risk or no recent history of risk for serious behaviors such as those which pose a danger to themselves or others. While the majority of these cases reflect local attempts to provide early intervention services, others may indicate a misuse of CSA.
- The eligibility and assessment process used in many localities does not reflect the intent of statute. Specifically, 49 percent of the children who received CSA-funded treatment services were given access to the program by local staff without use of the multi-agency review process described in statute. Further, in a number of localities, CSA staff either misclassified some children, or manipulated the system to establish eligibility for youths under the "mandated" service provisions of the statute.
- In terms of the placement of children into treatment programs, approximately 70 percent of the children who are approved for services were initially provided treatment in a community-based setting. Most of the remaining children received treatment in residential group homes. However, when these placement decisions were examined based on the risk of the child, JLARC staff found that in about half of all cases, the treatment-setting could not be justified.
- There is little evidence from this study to indicate that local CSA staff work to negotiate lower rates from providers after a decision to fund a particular treatment plan has been made. In addition, CSA staff do not typically engage in a systematic review of the services for which they contract. Partially as a result of this, the cost of care under CSA has risen substantially over the past four years.
- If the inefficiencies present in the local implementation of CSA are addressed, outcome data collected for this study indicate that the program has considerable promise. More than 70 percent of the parents and guardians of children who received services through CSA indicate that the program has helped to stabilize their child's behavior in the community, at home, and at school.
- In terms of the State oversight and management of CSA, it appears that the demands created by this program cannot be adequately addressed within the framework of the current management structure. Due to a decline in top leadership interest and guidance from the State Executive Council, staff shortages, poor com-

munication, the lack of statutory authority, and the limited actions of the Office of Comprehensive Services, there are critical gaps in the State level oversight of this program.

- Finally, State officials should be encouraged to pursue the use of Medicaid funds to offset some of the cost of CSA to both the State and localities. This effort could generate an estimated \$41 million in CSA savings (approximately \$25.9 million in State savings and \$15.4 million in local savings).

CSA Caseload Growth and Cost Increases Have Been Driven by Factors Which Are Mostly Beyond the Control of Localities

One of the major questions concerning CSA is whether substantial cost savings can be generated for the program through changes in local policies and program implementation strategies. This issue has emerged in CSA because localities have wide latitude in organizing their local programs, raising the possibility that CSA caseloads and costs have been unnecessarily increased through well meaning, but misguided local strategies.

The data collected for this study point to problems with the local implementation of CSA but provide no evidence that the growth in the program's caseloads and cost trends could be significantly reduced by focusing primarily on local reforms. Rather, the growth in CSA caseloads has been most influenced by increases in factors which serve as proxies for poverty (increase in the number of food stamp recipients), and a breakdown in the family structure (increasing foster care caseloads).

Evidence of the impact of these factors can be found in data collected on the families of CSA participants. This information reveals that the majority of these youths

have been reared in low-income, dysfunctional families in which some of the cruelest forms of abuse and neglect were regularly substituted for proper nurturing (see Table on next page). Most disturbing, approximately one in five of all of the children in the program have been sexually abused, typically by someone in their own family.

Once children from these types of families enter CSA, the cost of serving this population is driven less by the local strategies that are used to manage the cases and more by the problems of the relevant child. Undoubtedly related to the various forms of abuse they faced as children, 41 percent of the youths in CSA have problems with conduct disorder, almost half (47 percent) are considered defiant to persons in authority, more than half (56 percent) were diagnosed with emotional problems, 45 percent have impulse control problems, and almost one-third of the population were receiving psychotropic medication when they first entered CSA.

This does not mean that the implementation policies of local governments have no impact on the expansion of the CSA program. In fact, the data show that localities are reaching deeper into the pool of the CSA-eligible population to provide services to children and their families. The primary purpose of these early intervention efforts, typically labeled foster care prevention, is to prevent the break-up of the family. However, because these children are brought into CSA before they develop severe emotional or behavior problems, they do not exhibit the risk behaviors of other children in the program. Partially as a result, approximately one-half of the children in CSA had either no risk at the time they first received services (33 percent), or only a history of risk (17 percent).

These findings suggest that a policy change to reduce the number of low risk children entering CSA through early intervention programming could drive down the

**Family Characteristics of CSA Participants
Who Received Services in FY 1995**

| Family Characteristics | Aggregated Average (Percent) | Category of Eligibility | | | |
|---|------------------------------|---|-----------------------|----------------------------------|------------------------|
| | | Special Education Private Tuition (Percent) | Foster Care (Percent) | Foster Care Prevention (Percent) | Non Mandated (Percent) |
| Living with Both Parents | 14 | 28 | 10 | 15 | 19 |
| Medicaid Eligible | 68 | 36 | 76 | 51 | 62 |
| Receiving AFDC | 58 | 27 | 66 | 42 | 57 |
| Parents Abuse Drugs | 55 | 32 | 62 | 48 | 52 |
| Parents Have Criminal Record | 35 | 22 | 39 | 26 | 23 |
| Child Abused Prior to CSA Referral | 74 | 41 | 90 | 51 | 45 |
| Child Sexually Abused Prior to CSA Referral | 21 | 22 | 21 | 11 | 19 |
| Total Unweighted Cases | 1,144 | 143 | 719 | 115 | 100 |

total cost of the program in the short term. However, such an approach runs counter to the prevention language currently in the CSA statute and may have long-term cost implications as well. Rather than tightening the eligibility criteria and risk denying early intervention services to children from troubled homes, CSA would be better served if localities ensured that cases in which families need only social services to prevent the removal of the child from the home are managed by welfare staff, completely apart from the CSA program. This could end the current practice of some localities who use this foster care prevention provision of CSA to pay for family social services, rather than counseling.

Recommendation. *The General Assembly may wish to amend the Code of Virginia to remove the funding for the family foster care program and basic social services out of the CSA budget and transfer it back into the Department of Social Services. Approximately ten percent of the FY 1997*

CSA budget, or \$15 million, should be transferred from the CSA State pool of funds to the Department of Social Services for FY 1999. The CSA funding formula for this and subsequent years should reflect this change.

There Are a Number of Ways Through Which Localities Can Improve the Efficiency of CSA

There is a strong emphasis in CSA legislation on placing the responsibility, authority, and accountability for the program with local jurisdictions. The underlying premise of the legislation is that local governments are better able to develop the customized service plans that many at-risk youth need without the restraint of State regulations. However, the expectation of this legislation is that these same localities will put the necessary policies in place to ensure that eligible children are accurately assessed and placed in the most appropriate level of care at the lowest possible cost.

The data from this study indicate that local governments have not taken the nec-

essary steps to improve the cost-efficiency of the program. Nor, in many cases, are their local practices in line with the legislative intent of CSA. For example, CSA legislation encourages local agencies to use multi-agency teams to plan and organize the delivery of services for eligible children as a means of ensuring that the most cost-effective treatment strategies are used. Despite this, children are given access to CSA by local staff who routinely eschew this approach to planning and monitoring CSA services by making unilateral decisions about the treatment for the children on their caseloads.

To circumvent those aspects of the program eligibility criteria that are regarded as too restrictive, CSA staff in half of the localities across the State admit that they manipulate the system and establish eligibility for children who do not meet the requirements of certain provisions of the statute. In some other localities which have chosen to provide funding only for children who are "mandated" by State statute, CSA staff are misclassifying "non-mandated" children to ensure that they will receive services.

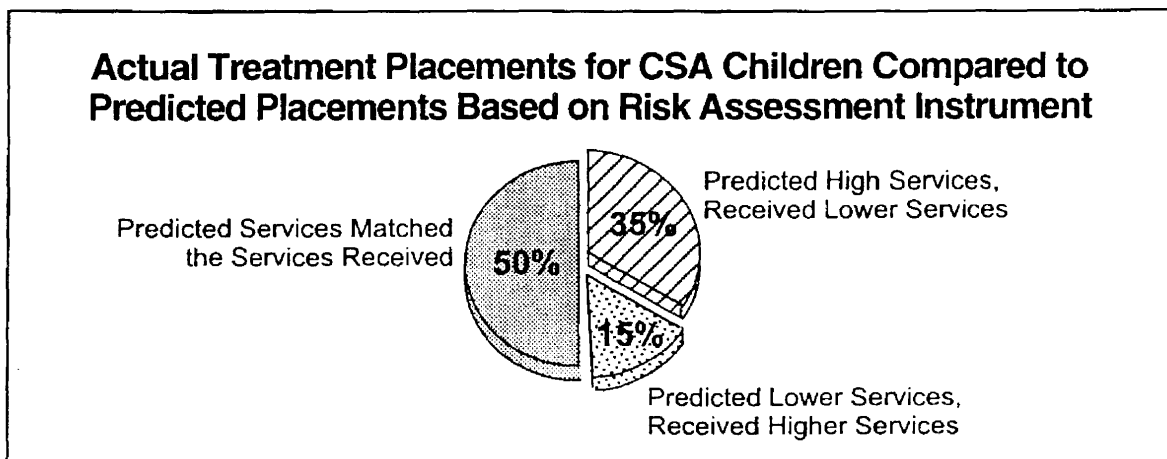
In terms of service placement, there is little uniformity in the methods used to identify the treatment needs of CSA participants both within and across localities. One consequence of this is that case managers and members of local multi-agency teams often

place children in a level of care that does not appear appropriate based on their risk to themselves or society (see figure below). In some cases, children who could have received treatment in less restrictive and less expensive settings were placed in higher cost residential programs. In other cases, children who appeared to need more structured settings were placed in community-based programs.

Equally significant, when establishing agreements with providers, many case managers and multi-agency teams are either reluctant or unable to negotiate lower rates for the requested services. Partially as a result of this, sharp increases in the per-day cost of residential and community-based care have occurred under CSA.

Finally, only a few localities have established systematic programs of utilization review to monitor the degree to which the services received by CSA participants are necessary, appropriate, and consistent with the stated plans of the provider. Therefore, potential problems found by JLARC staff with provider treatment plans, progress notes, and patient discharge summaries are typically not detected by local CSA staff. Some of the recommendations offered to enhance the cost-effectiveness of the program are as follows:

Recommendation. *The General Assembly may wish to amend Section 2.1-755*



of the Code of Virginia to require all cases for which treatment services (not foster care maintenance) are requested to appear before a local multi-agency team prior to the development of the service plan. Cases for which service plans are developed outside of this process should not be eligible for CSA funding.

Recommendation. *The General Assembly may wish to require that the State Executive Council develop a mandatory uniform assessment process to be used by all localities which identifies the appropriate level of care for various levels of risk. This can help to ensure that CSA participants will be served in the least restrictive environment.*

Recommendation. *The General Assembly may wish to require that the State Executive Council develop mandatory uniform standards for utilization review for all providers of CSA-funded services.*

Outcome Indicators for the Study Suggest that CSA Has Promise

Many of the youth served by CSA have serious and deep-rooted problems. It is not realistic to expect that CSA will "cure" these children, and in fact the CSA statute does not state this goal. Rather, one of the basic purposes of the program is to stabilize the child through the provision of services in the least restrictive environment, preferably the child's home or community.

There were encouraging indicators from this study that suggest that CSA may be having some success in achieving its goal. Based on an analysis which tracked the movement of children between treatment settings, JLARC staff found that the greatest increase over time was in the proportion of children who moved into less restrictive settings than their initial placements. This finding suggests that some progress is being made in moving children to less restrictive settings and less costly settings.

Also, survey responses from 200 parents or guardians of CSA children indicate that desired outcomes have been occurring. While in most cases problem behaviors certainly did not disappear with the provision of CSA services, the infrequency with which these problems were reported to have occurred after CSA services were provided, suggest that there was some degree of stability in the behavior of these children. CSA parents or guardians reported that school performance generally improved. Moreover, 70 percent of these parents or guardians thought the services provided through CSA helped to improve their child's behavior.

The results from this review should be viewed as a first step in the direction of considering CSA performance, rather than a definitive conclusion that CSA alone caused these positive outcomes to occur. The analyses were conducted based on data that were being assembled for the first time as a part of this review. It was not feasible in this review, however, to use an experimental design or have a true pre- and post-treatment comparison.

In the long-term, there is a need to develop performance measures for CSA which can be used to evaluate the success of the program over time. Such performance measures could address issues such as: whether service placements for children appear appropriate or are based on appropriate guidelines; whether service goals are well-documented and are being met; and whether the behaviors of the youth appear to be more stable after services are received.

Recommendation. *The State Executive Council should form a work group to identify the data needs and reporting requirements for a system of performance standards for CSA. This work group should establish the basic parameters of the performance assessment system that would be used statewide to evaluate local decisions regarding levels of care and participant outcomes.*

The State Management Structure for CSA Should Be Revisited

One of the reasons that CSA was considered such a unique program when it was created over five years ago relates directly to the State management structure that the General Assembly established for the program. Unlike the traditional oversight model in State government in which a single agency is vested with the policy development, management, and oversight responsibilities for locally implemented programs, the State-level structure is predicated on the concept of inter-agency cooperation and local control.

Accordingly, through a legislatively mandated two-tiered management structure, the CSA State Executive Council was established to direct the program oversight and policy development activities of the program, while receiving policy advice from a State Management Team, and staff support of the Office of Comprehensive Services.

By almost all accounts, this structure has not worked well. Perhaps because no one agency is responsible for CSA, the interest of the agency directors who serve on the Council appears to have waned over time. This has slowed progress on the policy work needed to establish a program of utilization review for CSA, as well as proposals for alternative funding sources to provide relief to local governments for the growing costs of CSA. In addition to these problems, persistent disputes, poor communication, and confusion about the roles among the Council, its management team, and the Office of Comprehensive Services have worked against this non-traditional approach to State oversight. Moreover, the quality of the support which the Council needs from the Office of Comprehensive Services has been seriously hampered by the agency's lack of staff.

Partially as a result of these problems, the most basic elements of an effective

management structure — consistent oversight, role clarity among key entities, strong policy guidance and quality technical assistance — are largely absent from the CSA State management structure. As the size and complexity of local CSA programs has grown, the emerging oversight, technical assistance, and policy analysis demands of the system cannot be accommodated within the current State structure. Thus, while local officials should retain the flexibility to design and deliver the range of services that are needed for at-risk children in their jurisdictions, it is imperative that a stronger policy development, oversight, and management role be established at the State level.

As a part of an increased emphasis on policy development, the State Executive Council should more actively explore the potential benefits of developing a closer link between CSA and the Medicaid program. While such a nexus will necessitate some administrative changes at the local level, it will increase program accountability, and the potential cost savings to the State and localities are substantial. JLARC staff estimate that approximately \$41 million of the costs of CSA could be appropriately shifted to the federal government. In addition, the use of Medicaid funds would require that local governments standardize the client assessment process and more aggressively monitor providers to ensure that the appropriate level of care is provided.

Recommendation. *The Office of Comprehensive Services should establish a systematic monitoring mechanism for assessing local funding and operation activities to ensure they are consistent with the requirements of State statute and the intent of CSA. The Office of Comprehensive Services should require localities to submit all local internal audit results which pertain to CSA.*

Recommendation. *The General Assembly may wish to require the Department*

of Medical Assistance Services to amend its State plan to include Medicaid payment for residential care and therapeutic foster care. The State Executive Council should work with the Department of Medical Assistance Services on the use of Medicaid funds for assessment and case management functions.

Recommendation. The General Assembly may wish to amend the Code of Virginia to add the chair of a local Community Policy Management Team to the State Executive Council. If a decision is made to establish a closer link between CSA and Medicaid, the General Assembly may also wish to add the Director of the Department of Medical Assistance Services to the Council.

Recommendation. The General Assembly may wish to amend the Code of Virginia to dissolve the State Management Team and authorize the State Executive

Council to appoint work groups on an as-needed basis. Among its members, these work groups should include regional representation of local CSA officials and State agencies.

Recommendation. The General Assembly may wish to amend the Code of Virginia to establish the Commissioner of the Department of Mental Health, Mental Retardation, and Substance Abuse Services as the permanent chair of the State Executive Council.

Recommendation. The General Assembly may wish to amend the Code of Virginia to establish the Office of Comprehensive Services as a division of the Department of Mental Health, Mental Retardation, and Substance Abuse Services. The Office of Comprehensive Services would act as the administrative arm of the State Executive Council and as such would maintain the operational duties of the CSA program.

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I. Introduction

With the passage of the Comprehensive Services Act in 1992, Virginia became one of the first states in the nation to develop, fund, and implement a statewide comprehensive system of care for children with emotional and behavioral problems. Over the last two decades, research has shown that increasing numbers of children are developing severe mental, emotional, and social problems which thwart their development as productive adults. While the root causes of these problems are the source of much public debate, many of these “at-risk” children share a number of common problems. Most are reared in dysfunctional families where they are often the targets of various forms of emotional, physical, and sexual abuse. Many live in neighborhoods which lack strong role models and are replete with the dangers that accompany the illicit trades practiced by some in these communities. Finally, these children are usually failing in school because of truancy, conduct problems, and/or learning disabilities.

The impetus for the legislation that established the Comprehensive Services Act (CSA) was work conducted by the State’s executive branch which not only highlighted a growing demand for mental health services, but also identified significant problems in the way the Commonwealth organized and delivered these services to at-risk children. Prior to CSA, programs for at-risk children were supported through multiple funding streams and were characterized by excessive per-participant costs, unequal access to care, and double-digit growth rates.

With CSA, a new delivery system for at-risk youth was established that differed from its predecessor in two important ways. First, the multiple funding streams which supported the previous system were consolidated into one pool of funds for the program. Next, CSA was organized on the principles of local service coordination among human resource agencies, greater local flexibility to design treatment plans, and a more extensive use of community-based services.

In the four years since CSA was adopted on a statewide basis, there have been no large scale studies of the program. Consequently, as the size and cost of the program has grown during this time period, questions have emerged concerning whether localities are implementing CSA in a manner that is both cost-effective and consistent with legislative intent. As a result, the General Assembly passed two study resolutions — Senate Joint Resolutions 123 in 1996 and 371 in 1997 — and placed language in the 1997 Appropriation Act requesting a comprehensive study of CSA.

This report presents an analysis of CSA based on data collected from program staff in various localities and the files of children who have received services. The remainder of this chapter discusses problems with the pre-CSA service delivery system and outlines the purpose and goals of the program. Additionally, CSA’s eligibility criteria and the range of services which can be paid for through the program are examined

THE EVOLUTION, PURPOSE, AND STRUCTURE OF THE COMPREHENSIVE SERVICES ACT

Prior to 1993, four major human service agencies were separately responsible for providing services designed to address the emotional and behavior problems of at-risk youth. At that time, there were 16 different funding streams which supported the programs used by these agencies to pay for certain services. In FY 1989, these agencies spent more than \$53 million on programs and residential services for at-risk children. By FY 1993, this figure had increased to \$89 million – an average annual rate of growth of 14 percent. Based on a study by the Department of Planning and Budget, there was general agreement that this fragmented system fostered service duplication while encouraging the delivery of services through the more expensive residential treatment settings.

With the passage of CSA in 1992, Virginia became one of the first states to legislate the development of a coordinated system of treatment for at-risk youths. The goal of this legislation is to encourage collaborative arrangements among local agencies through which various services can be funded to address the emotional, educational, and social needs of at-risk children.

Under this new system, local human resource agencies maintain the separate systems that have been historically used to provide treatment services for various groups of children. For example, community-service boards still offer services for persons who are mentally ill. However, the legislation for CSA creates a pool of State funds from nine categorical funding streams which is distributed to each locality by formula. Using resources from this pool of funds, the human service agencies in the localities are now required to form a multi-agency team to plan and implement a coordinated assistance plan for a certain group of at-risk children – those whose treatment needs are beyond the capacity of any one human service agency. Also, where past programs for this population were funded with the laudable purpose of “curing” the child, CSA embraces no such goal. Rather, one of the basic purposes of the program is to stabilize the child through the provision of services in the least restrictive environment, preferably the child’s home or community.

Within this framework, the architects of CSA agreed on three central premises. First, localities should be given considerable discretion and control over the program. Second, the structure in which this discretion is exercised should include participation by representatives of each major human resource agency in the jurisdiction. Third, certain groups of children are to be considered mandated and the services they require should be funded “sum sufficiently.”

Beyond this, and in keeping with the philosophy of local control, there are no State prescriptions on what services should be delivered through CSA, how services are to be monitored, and how long services can be provided. Moreover, other than preservation of the family unit and a reduced reliance on institutional treatment, CSA

legislation is silent on what the long-term goals of this program should be for the children who receive services.

Prior to CSA, the Service Delivery System for At-Risk Youth Had Numerous Problems

Before the legislation establishing CSA was implemented in FY 1994, the service delivery system for at-risk youth was a complex arrangement involving four major human services agencies. The key agencies in this system were: (1) the Department of Youth and Family Services (DYFS); (2) the Department of Education (DOE); (3) the Department of Social Services (DSS); and (4) the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS). The local programs that were operated or funded by these agencies were supported through various categorical block grants which had different eligibility requirements and varying match requirements for participating local governments. Still, although the State laws and policies governing these agencies were different, there was often considerable overlap among the youths who were served.

Duplication of Services. As shown in Table 1, each of the agencies responsible for the provision of services to at-risk youth operated separate and extensive local delivery systems. Nonetheless, they often provided similar types of services to youths with comparable emotional and behavior problems. For example, while DMHMRSAS was solely responsible for the operation of the State's psychiatric hospitals, its 40 community service boards (CSBs) operated group homes for troubled youth. Although a youth had to be mentally ill to receive services through this system, the youth may also have been a foster child, a juvenile offender, and/or a special education student. As such, this youth was eligible for, and may have received similar services through programs operated by other agencies. Without multi-agency planning and service coordination, it was possible in some cases that a local agency would prescribe and fund treatment options that may have already proven ineffective in addressing the needs of the child.

In other cases, the categorical nature of the funding streams made it difficult for children to receive services simultaneously from more than one agency. For example, while receiving special education services, a youth was considered a "special education child" and was viewed primarily as the responsibility of the local school system. If this child required services that were not typically offered by the school system, in many cases those needs may not have been addressed at that time.

In its study of this issue, staff at the Department of Planning and Budget (DPB) attempted to quantify the overlap across these agencies by examining the names of more than 14,000 youths who received residential services through any of the funding streams which supported the local programs. When the databases for these agencies were matched by the name of the youths who received services across the four separate systems, only 4,993 unique entries could be identified. As a result of this finding, DPB was concerned that the same children were moving from one funding

Table 1

Pre-CSA Service Delivery System for At-Risk Youth in Virginia

| State Agency | At-Risk Youths Served | Service Delivery System | Residential Programs Operated | Services Purchased |
|--------------|--|---------------------------------|---------------------------------------|---|
| DMHMRSAS | Mentally Ill (including juvenile offenders, foster children, and special education students) | 40 Community Service Boards | Psychiatric Hospitals and Group Homes | Community-Based Counseling |
| DSS | Foster Children (including juvenile offenders, special education students, and mentally ill youth) | 124 Local Agencies | None | Community-Based Counseling Residential Care |
| DYFS | Juvenile Offenders (including the mentally ill, special education, foster care children) | 35 Court Service Units | Correctional Centers Group Homes | Detention Community-Based Counseling Residential Care |
| DOE | Special Education (including mentally ill youth, juvenile offenders, and foster care children) | 135 Local Education Authorities | None | Residential Care |

Source: *A Study of Children's Residential Services*, the Department of Planning and Budget, June 1990.

stream to another, possibly receiving the same types of services, irrespective of the success and appropriateness of treatment.

Unequal Access to Treatment. In addition to the problem of service duplication, there were also local inequities in the services provided. These inequities were largely a function of the financial matching requirements associated with some of the categorical funding streams (Table 2). For example, the funding stream for the placement of foster care children in residential treatment programs was a block grant from the State. Because the funds from this grant were used to purchase other services as well, DPB reported that localities typically spent their entire allocation before the end of the fiscal year. In these cases, local governments had the option to pay for any additional residential placements by shifting funds from the State/local foster care program. However, because this program had a 50 percent matching requirement, DPB found that poorer localities were less likely to use this strategy.

Table 2

Local Match Rates for Pre-CSA Funding Streams

| Agency | Funding Stream | Local Match Rate |
|------------------------------|--|--------------------------------------|
| DMHMRSAS | State Psychiatric Adolescent Units Community Group Homes Bed Purchase Funds | 0% Varied 0% |
| *DYFS | *Learning Centers 286 Special Placements 239 Special Placements 294 Special Placements Block Grant Program State Halfway Houses | 0% 0% 0% 0% Varied 0% |
| DOE | Private Tuition Assistance Interagency Assistance Fund | 18% to 80% 0% |
| DSS | Federal IV-E Foster Care State/Local Foster Care Social Services Block Grant Supplemental Foster Care | 0% 50% 20% 20% |
| State Interagency Consortium | Interagency Funds Pool | 0% |

Notes: *This agency is now called the Department of Juvenile Justice and learning centers are now referred to as juvenile corrections centers.

Source: Council on Community Services for Youth and Families, *Improving Care for Troubled and "At-Risk" Youth and Their Families*, November 1991.

Reliance on More Expensive Forms of Care. While variations in the categorical match requirements limited access to treatment in some localities, the absence of cost-sharing for some of the most expensive forms of care (such as psychiatric hospitals) removed the incentive for local agencies to curb the use of this type of care for at-risk youth. As an example, local judges would in some cases place troubled youth in State-funded learning centers and psychiatric hospitals to access treatment programs that were funded at 100 percent by the State. Although some of these services may have been available in the community, the local match requirements worked against the use of community-based placements. This was considered a key factor by DPB in explaining why 78 percent of the funds spent on residential services for at-risk children in 1989 were used for the more restrictive out-of-community placements.

Based on these and other figures, DPB estimated that the General Assembly would need to allocate an additional \$42 million for the 1992-94 biennium in order to meet the growing demand for these services. Furthermore, future costs for these services were projected to grow at an average annual rate of 22 percent. In testimony to

the Congressional Select Committee on Children, Youth, and Families, the Governor of Virginia at that time summarized the problems of the system in this way:

Troubled youth and their families have multiple needs. These youth often “bounce” from agency to agency, from foster home to group home to institution, from funding stream to funding stream. A child is often removed from his or her home, and the problem is “fixed.” All too often, the child is then returned home without adequate support. Clearly, the emotional costs to children and families are extremely high...The financial costs to taxpayers for this unproductive cycle are high. Rather than provide community services tailored to strengthening the family and encouraging self-reliance, government may in fact encourage the use of more restrictive and costly care through our categorical programs and funds.

CSA Structured to Address Shortcomings in the System

In response to the concerns expressed in the DPB study, the General Assembly mandated the formation of a cross-secretarial interagency task force to recommend ways to improve service delivery for troubled youth. As a part of their mandate, this task force was asked to give special consideration to options that would help contain the growing costs of residential care. To carry out this mission, the task force held regional meetings across the State, and received written comments from interested communities. Relying on this input, and its own philosophy, the task force concluded that local flexibility, service coordination, and community treatment should be the foundation of any new system for serving at-risk youth.

Based on the recommendations of the task force, the General Assembly awarded \$2.4 million to five communities to establish demonstration projects. Because the results from these 1991 projects were viewed as positive — greater local coordination, reduced reliance on residential treatment, lower unit costs — the General Assembly adopted the language of the Comprehensive Services Act in 1992.

Goals of the CSA Funding Structure. When CSA was established, the General Assembly outlined two sets of goals. One set of goals focused on the General Assembly’s objectives for the local implementation of CSA, and another set were primarily related to the intent of the program’s funding structure. Outlined in Section 2.1-757 of the *Code of Virginia*, the following goal statement clearly articulates the General Assembly’s intention of eliminating the counterproductive incentives that were considered a major aspect of the old system:

- to place authority for making program and funding decisions at the community level;
- to consolidate categorical agency funding and institute community responsibility for the provision of services;

- to provide greater flexibility in the use of funds to purchase services based on the strengths and needs of youths and families; and
- to reduce disparity in accessing services and to reduce inadvertent fiscal incentives for serving children according to differing required local match rates for funding streams.

To carry out these funding goals, one of the most significant changes created by CSA was the establishment of a State pool of funds. As it was not the intention of the legislature to categorize at-risk children by funding streams as a basis for receiving services, the State pool of funds was created by combining resources from nine different categorical programs. As Figure 1 reveals, the largest share of the State pool, \$43 million, was drawn from the State and Local Foster Care program. DOE's private tuition and interagency assistance funds of more than \$29 million represented 36 percent of the pool. The next largest contribution of \$11.3 million was made from the 286 and 239 Special Placement funds (named according to their location within Section 16.1 of the *Code of Virginia*) that had been previously used by DYFS to purchase services for juvenile offenders.

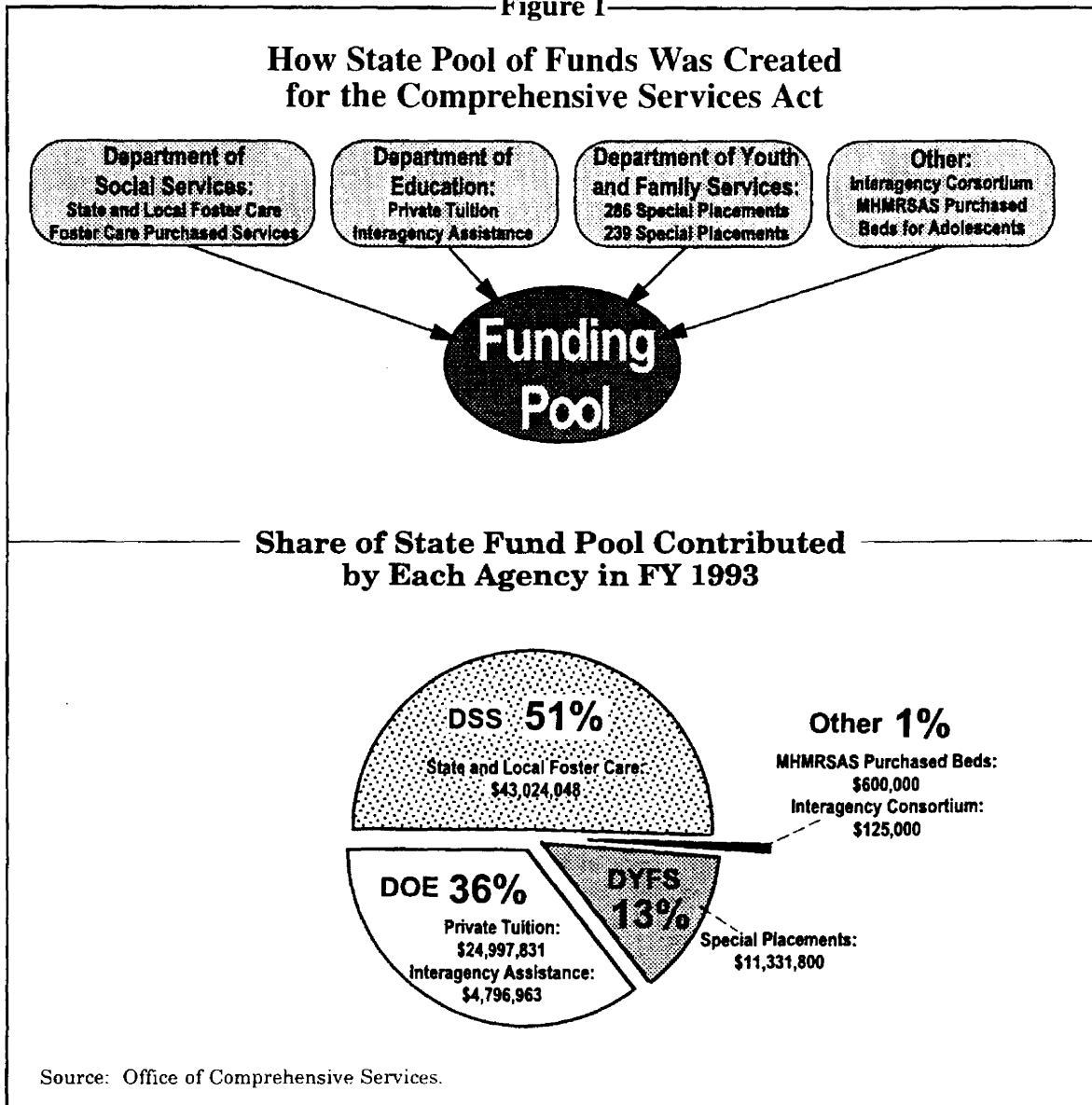
As a supplement to this pool of funds, the General Assembly also established a State trust fund. The primary purpose of this fund is to support local community-based programs which are designed as early intervention initiatives for at-risk youths. These funds are distributed by the State as special grants based on the recommendations of local officials.

Use of Formula to Distribute Pool Funds. In keeping with CSA's emphasis on increased local control and flexibility, the funds from a State pool are allocated to localities by formula. A locality's allocation consists of two parts — a base allocation and a growth allocation. Each locality's base allocation is the amount of State CSA funds that it received in FY 1995. In the original CSA legislation, the base allocation was the amount of funds a locality received from the nine funding streams in FY 1992. This provision was intended to ensure that no locality would receive less State money as a result of CSA. The 1996 Appropriation Act updated the year for the base allocation to FY 1995.

The growth allocation represents any CSA funds appropriated by the General Assembly in excess of the base allocation. These funds are distributed by formula based on the relative size of a locality's youth population.

Local Matching Requirements. Localities are required to provide matching funds in order to receive funds from the CSA State pool. As with the State allocation, locality matching funds have both "base" and "growth" components. The locality's match for the State's base allocation is the amount the locality paid in FY 1995 to match State funds. The locality's match rate for its State growth allocation is determined by a formula that measures ability to pay. However, a locality's match rate cannot be higher than 45 percent. The CSA funding structure thus replaced the variety of matching rates that existed in the old funding structure with a single match rate

Figure 1



as determined for each locality. Now, localities can no longer abuse the system by reducing the amount of local matching funds required by assigning a child to one program rather than another. Rather, localities now have to contribute matching funds for every State CSA dollar they receive, giving them greater incentive to monitor and control program expenditures.

Finally, localities also receive funds equal to one percent of their FY 1994 pool allocation (State and local funds combined) for CSA-related administrative expenses. The allocation for administrative expenses cannot be lower than \$5,000 or higher than \$25,000.

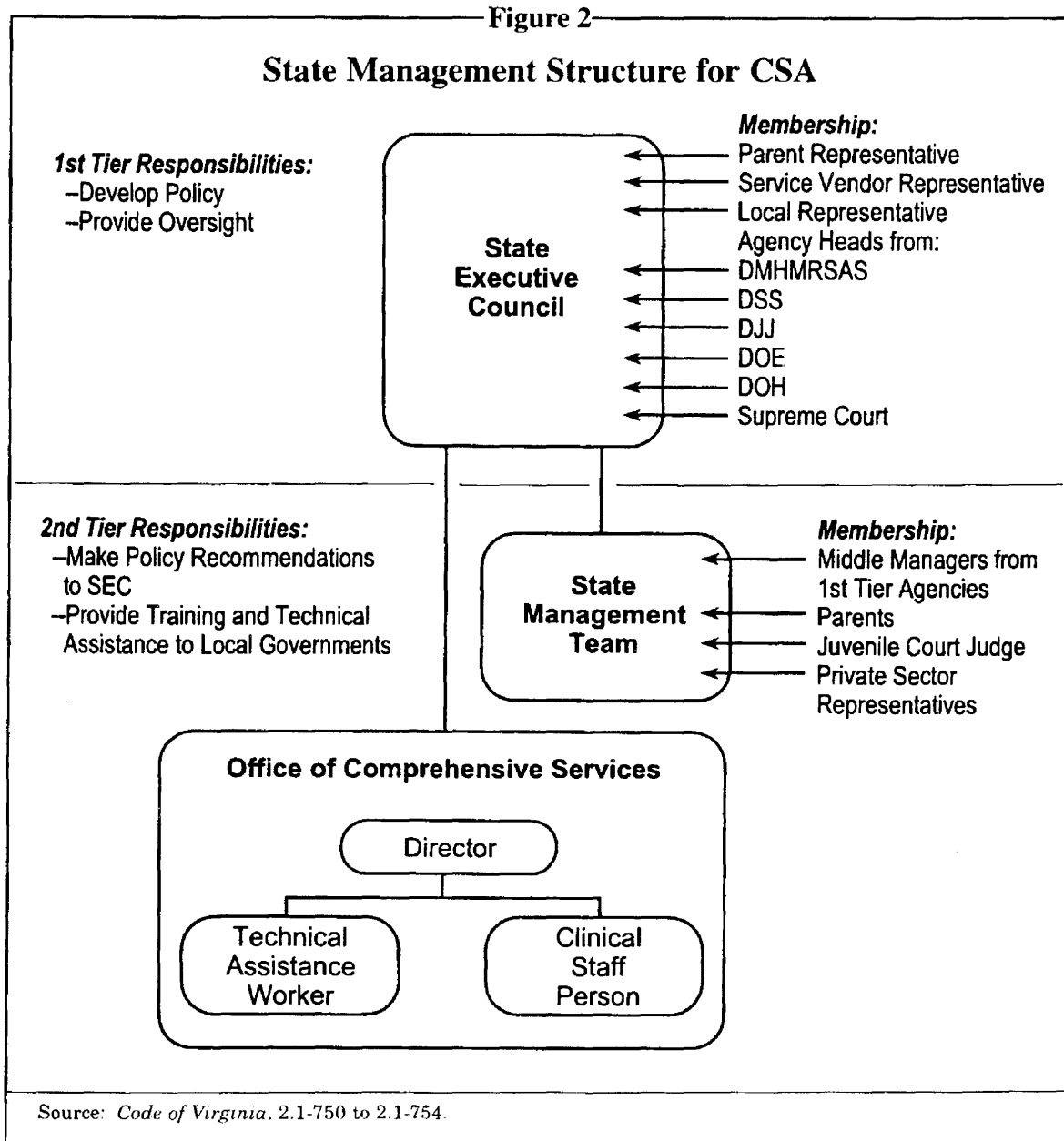
CSA Program Goals in Legislation. The second set of goals, which are more program related, are outlined in Chapter 880, Section 2.1-745 of the *Virginia Acts of Assembly*. It is through this language that legislative preferences for interagency collaboration, treatment for youths in the least restrictive environment, and public-private partnerships are outlined. These goals include the following:

- Ensure that services and funding are consistent with the Commonwealth's policies of preserving families and providing appropriate services in the least restrictive environment, while protecting the welfare of children and maintaining the safety of the public.
- Identify and intervene early with young children and their families who are at-risk of developing emotional or behavioral problems, or both.
- Design and provide services that are responsive to the unique and diverse needs of troubled youth and their families.
- Increase interagency collaboration and family involvement in service delivery and management.
- Encourage a public and private partnership in the delivery of services to troubled and at-risk youth and their families.
- Provide communities flexibility in the use of funds and to authorize the communities to make decisions and be accountable for providing services in concert with these purposes.

In order to streamline the functions of several agencies by consolidating their activities for certain at-risk children into one structure, the General Assembly created a two-tiered State management structure to coordinate the CSA activities of each participating locality (Figure 2). The first tier of this structure consists of the State Executive Council which is the policymaking body of CSA. The second tier consists of a State Management Team.

Membership on the Council consists primarily of the State agency heads from DMHRSAS, DSS, DOE, the Department of Juvenile Justice (DJJ), and the Department of Health (DOH). In addition, the governor is required to appoint a parent representative to serve on the Council.

The primary responsibilities of the State Executive Council are policy development and program oversight. As a part of its responsibilities, the Council must oversee and monitor the distribution of CSA State pool and trust funds, ensure that each agency represented on the council provides the required amount of staff and resource support for CSA, take action on proposals or policy recommendations submitted by the State Management Team, and advise the governor of proposed changes in policy or operational practices.



The State Management Team is the second entity in the State's two tiered structure. Its membership includes staff — usually middle managers — from each of the State agencies that are represented on the Council, along with parents, juvenile court judges, and representatives from the private sector. In addition to making policy recommendations to the Council, the State Management Team is responsible for providing training and technical assistance to the local agencies that are involved with the implementation of CSA.

In carrying out its programmatic and technical support responsibilities, the management team receives assistance from the Office of Comprehensive Services for

Youth and Families. Organizationally, this office is independent of the agencies whose funds were pooled to create CSA; however, the office is staffed through positions allocated to it from these other State agencies. For example, the original staffing of the office consisted of a director (classified as a Department of Social Services position), a fiscal agent (classified as a Department of Education position), and a technical assistant (classified as a Department of Mental Health, Mental Retardation, and Substance Abuse Services position). The office is located at the Department of Social Services, except for the fiscal agent who works out of the Department of Education. As the operational arm of the State Executive Council, this State office is responsible for providing technical assistance to the localities while serving as a clearinghouse for inquiries and requests from local governments.

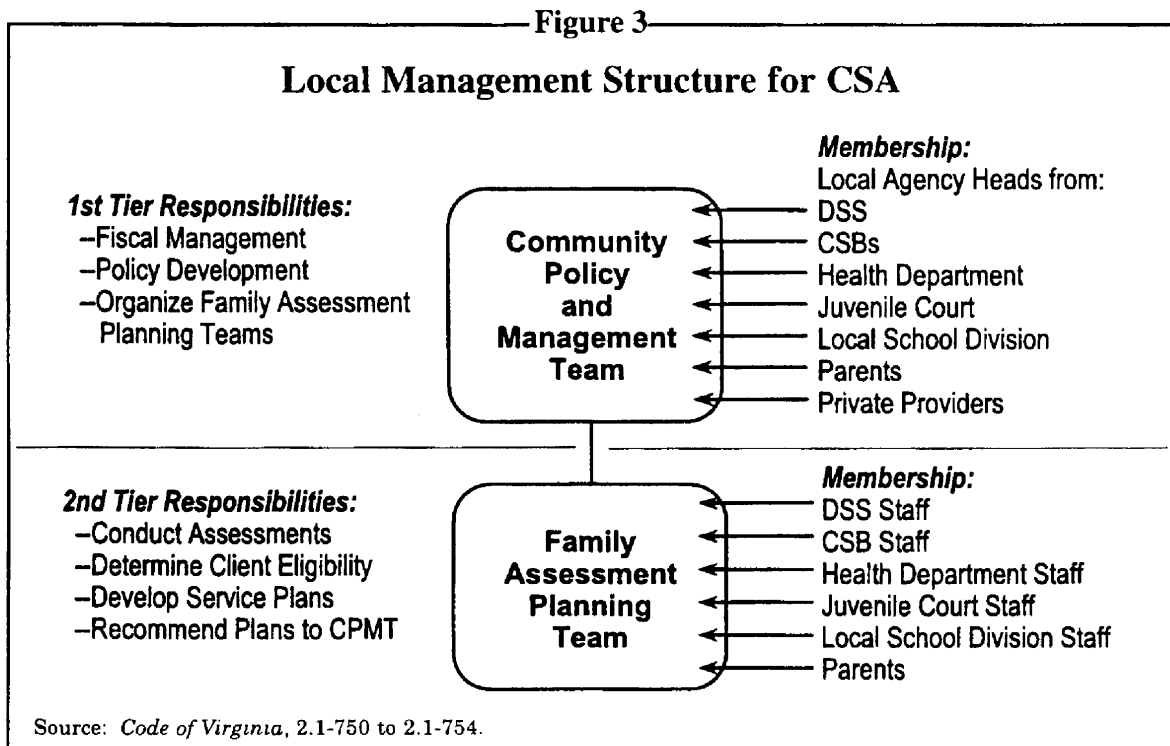
Two-Tiered Local Delivery System. As Figure 3 shows, the local management structure for CSA mirrors the State-level structure. In each participating jurisdiction, local officials are required to consolidate the interagency delivery system for at-risk youth into one structure. Through this structure, the planning, funding, and delivery of services for at-risk youth is carried out. As a condition of receiving CSA dollars, each jurisdiction must establish a Community Policy and Management Team which represents the first tier of the local structure.

While the local governing body specifies the membership and length of terms for certain members, at a minimum, this team must include the local agency heads from community services boards, departments of social services, health departments, juvenile court services units, and the local school divisions. A parent representative and a member of the private sector must also be appointed to the Community Policy and Management Team.

In effect, the management teams are the local counterparts of the State Executive Council and are considered the fiscal agents for the CSA program. As a result, they must develop policies to guide the use of CSA dollars and organize the second tier of the local management structure – the multi-agency planning and assessment teams. In most localities, these teams function as the centralized intake point or gatekeeper for the CSA system of services. Generally, it is the responsibility of the team to determine if each child referred to the program is actually eligible for CSA-funded services. For each eligible child, the team must conduct an assessment of the child and his or her family and develop an appropriate service plan.

CSA Eligibility Criteria Gives Higher Priority to Certain Groups

While CSA removes the categorical distinctions that existed under the old system, elements of that system were retained through CSA's eligibility criteria. In determining eligibility under CSA, program staff must complete what is essentially a two step process. First, staff must determine whether a child referred to CSA has a qualifying behavior or emotional problem. According to the *Code of Virginia*, the child must have behavior or emotional problems that either:



- 1(a). have persisted over a significant period of time or, though only in evidence for a short period of time, are of such a critical nature that intervention is warranted;
- 1(b). are significantly disabling and are present in several community settings; and
- 1(c). require services or resources that are unavailable or inaccessible, or that are beyond the normal agency services, or require coordinated interventions by at least two agencies; or
2. place the child in imminent risk of entering residential care and require services or resources that are beyond normal agency services or routine collaborative processes across agencies.

Next, based on Section 2.1-757 of the *Code of Virginia*, local staff must determine whether the eligible child is to be considered mandated or non-mandated. The category of "mandated youth" consists of those children for whom services were paid for sum sufficiently prior to the creation of the CSA pool of funds. In other words, these are the youths who, in the absence of CSA, would have been served by one of the categorical funds because of existing service mandates. This group includes special education students eligible for private tuition assistance, those in foster homes, or those who are at-risk of being placed in a foster home placement (otherwise referred to as foster care prevention cases). Localities must provide the CSA resources to purchase

the services deemed necessary for all mandated children, and this group has priority over other youth when localities make plans to spend CSA funds.

Targeted, non-mandated children and other eligibles (hereafter referred to as non-mandated) are those youths who are no more than 18 years of age and who, under the old system, were typically served in programs funded through DYFS and DMHMRSAS. However, because the funds from these agencies were capped — when the money was expended, no more services were purchased — a “sum sufficient” requirement was not imposed for this population under CSA. Thus, after a locality spends its allocation, no additional State CSA resources will be provided to serve any non-mandated child who had not received services.

Therefore, for the purpose of accounting for the funds in the State pool, localities must determine how a given applicant or referral should be classified based on these categories. Because of the “sum sufficient” requirement for the mandated population, the State and local fiscal implications associated with service to this group are significant.

CSA Funds a Range of Services for At-Risk Children and Their Families

In keeping with the concept of local flexibility, there are a range of service options through CSA to provide treatment to the children who are served through the program. Exhibit 1 describes some of the many services available under current program guidelines. It is important to note that CSA funds may also be used to pay for services for the family of a child who has been referred to CSA. However, all expenditures must be tied to an eligible child. Thus, a locality can use CSA funds to purchase mental health counseling for an eligible youth’s entire family, as long as the counseling services are considered a part of the youth’s treatment plan. This was allowed to ensure that CSA funds could be used to stabilize the family when the source of any identified problems was determined to be the parents and not the child.

Service Patterns Under CSA. The Office of Comprehensive Services does not currently collect data on the total dollars spent on each CSA funded service statewide. Instead, beginning with FY 1996, localities were required to report the total number of persons who receive various services during a fiscal year. Although these data do not allow a detailed assessment of services in terms of dollars spent, the information can be used to illustrate the general thrust of programming under CSA by showing the total number of persons who are reported by the localities to have received a particular service.

As shown in Figure 4, the most frequently funded CSA service in FY 1996 was foster care (43 percent). Only 23 percent of the persons who received a CSA funded service in FY 1996 were treated in either a residential group home, institution, or hospital. Most of the residential placements were in facilities with at least 13 beds. Specialized foster care (12 percent) and education programs (11 percent) were the only

Exhibit 1

Descriptive Overview of CSA Service Categories

Family Foster Care: This service involves the placement of the youth in another family setting, usually because of problems of abuse and neglect in the youth's own family.

Specialized Foster Care: This service involves the placement of the youth in an alternative family setting in which at least one of the guardians is specifically trained to work with children who have physical disabilities and/or emotional and behavioral problems.

Therapeutic Counseling Services: These are services provided in the community by professional counselors and psychologists to address psychological or other mental health related problems observed in the child. Services provided can include individual and family counseling, psychological evaluations, and therapeutic treatment groups.

Day Services: Day services are typically before and after school programs for children who are living in the community but need special attention and supervision while they are not in school. This service also includes regular non-therapeutic day care for children during a portion of the day.

Specialized Education Programs: These programs are alternative school programs for children who have been removed from the public school setting. These programs usually combine professional counseling with education instruction for persons who have severe learning disabilities or extreme behavior problems which prevent them from succeeding in a normal school setting. These services may also be provided through home-bound instruction.

Home-Based Services: These are services designed as a form of crisis intervention for children who are at imminent risk of being placed out of the home because of behavior problems or the poor parenting skills of their guardians. In some cases, these services can include 24 hour care by a trained specialist. In other cases, they may involve a trained worker spending a few hours each day in the home with the parent and the child. These services are also used as a part of an early intervention program for families that appear at-risk.

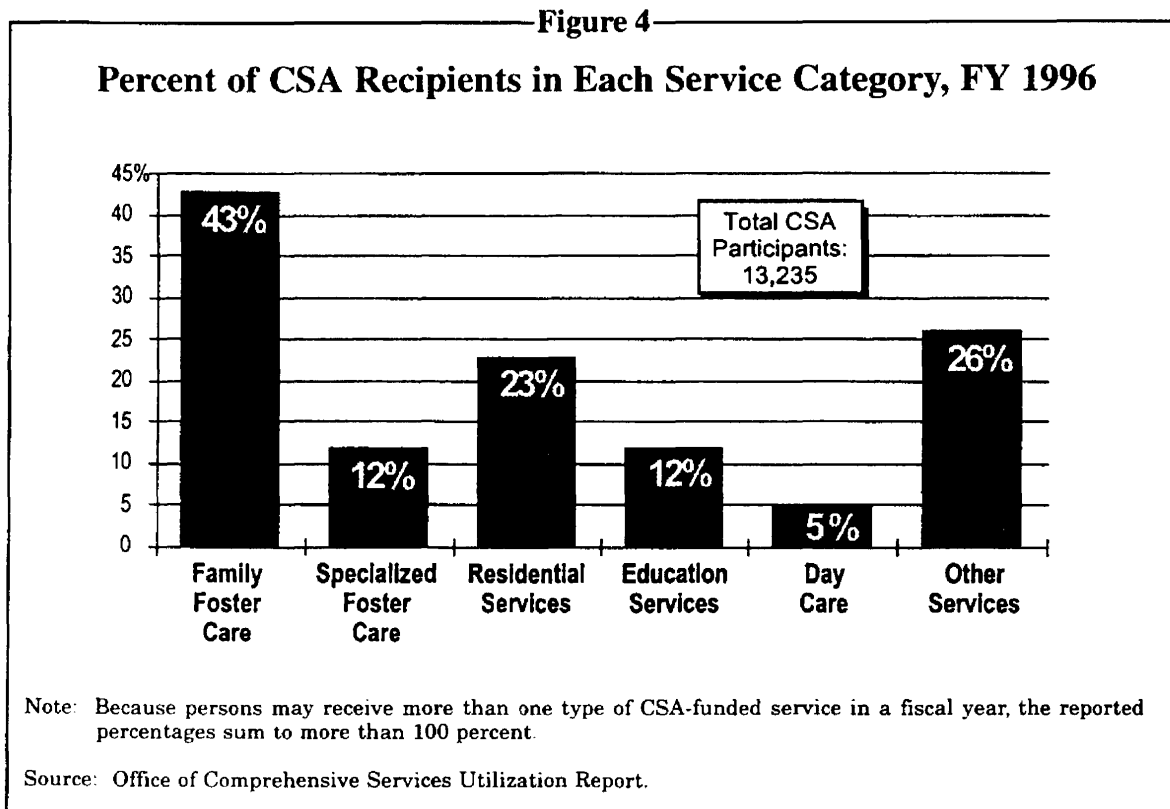
Residential Care: These are out-of-home placements that include: a non-therapeutic group home where a youth is placed to carry out the normal activities of daily living; therapeutic group homes where youths receive education, counseling, and physical conditioning on-site; and specialized medical facilities which are designed to treat youths with neuropsychiatric problems such as bi-polar disorder or schizophrenia.

Independent Living: These are services designed to assist a youth in the transition to adulthood. They include mentor programming, career or vocational counseling, financial assistance, and supervised living.

Case Management Services: This service is typically purchased to provide a child or family with a trained worker who is responsible for connecting the child or family to the appropriate services in the community, based on the child's needs.

Emergency Services: These are programs and services which are available 24 hours per day to address the needs of children and families for housing, mental health services, or other crisis stabilization services.

Source: Virginia Service Fee Directory.

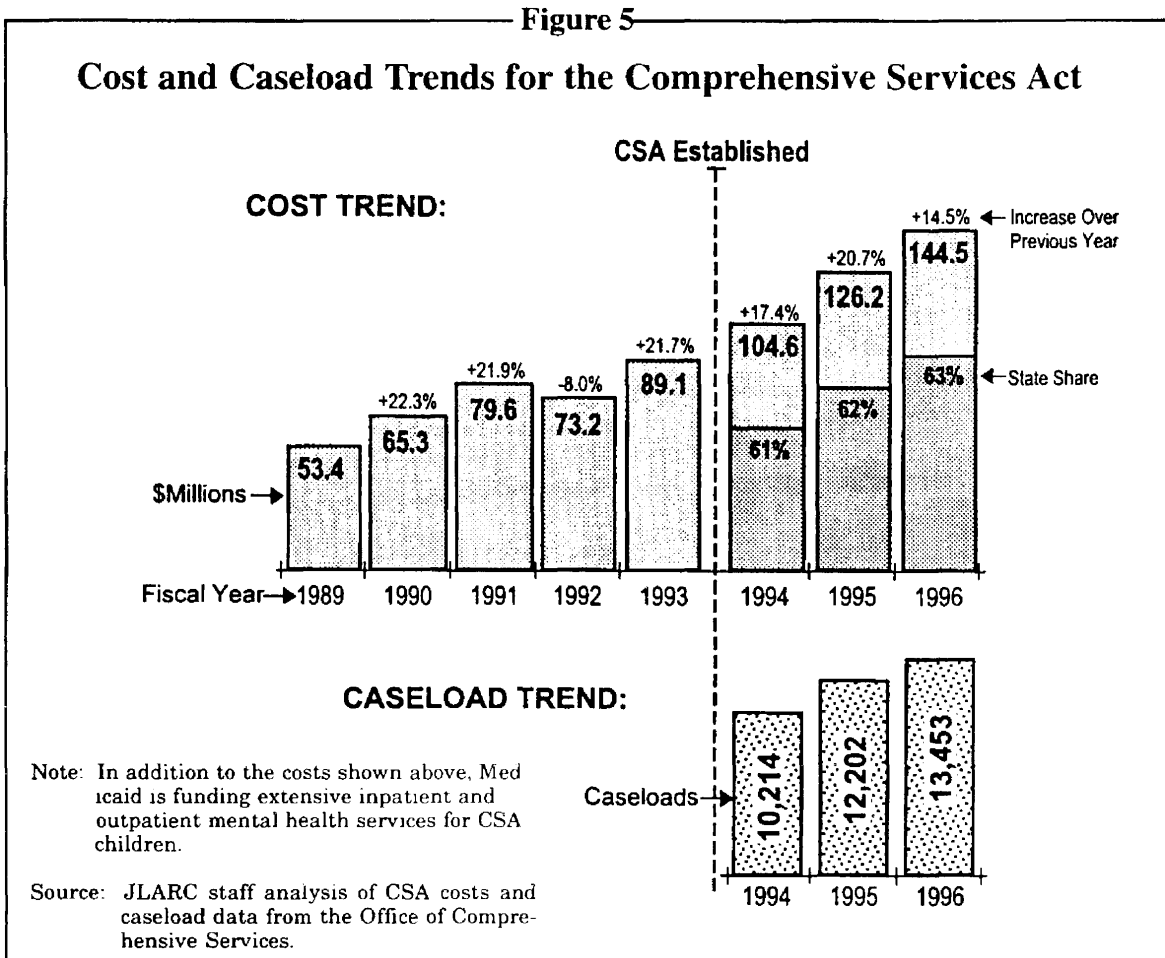


other services in which the number of participants were reported to exceed 10 percent. Reflecting the variety of services funded through the program, 26 percent were categorized as "Other".

CSA COST TRENDS

When CSA was first implemented statewide in FY 1994, the program was expected to lower the cost of serving at-risk youth. With its emphasis on service coordination and community-based care, both executive branch staff and legislators anticipated gradual reductions in the cost of this program. Nonetheless, in its first three years of implementation, the total cost of CSA has continued to increase (Figure 5). Specifically, in FY 1994, total CSA costs were more than \$104 million. By FY 1996, these costs had increased to \$144.5 million — an average annual rate of growth of 17.6 percent. This growth rate was a little higher than the average annual caseload growth rate of 14.7 percent.

As Figure 5 reveals, since the enactment of the CSA, program costs have continued to grow at a substantial annual rate. Total CSA expenditures have increased by more than 62 percent in the program's first three years of operation. Whether CSA has succeeded in slowing cost growth is a matter of interpretation. Average annual cost growth during the first three years of CSA has been 17.6 percent. For the period from



FY 1989 to FY 1993 that preceded CSA, program costs grew at an average annual rate of 13.7 percent. This lower growth rate, however, is distorted by the one-time drop in expenditures that occurred in FY 1992. With the exception of the drop from FY 1991 to FY 1992, program costs grew by about 22 percent from one year to the next prior to the CSA.

The data which would allow an assessment of whether caseload growth under CSA has occurred more rapidly than was experienced through the categorical programs for at-risk children are not available. Nonetheless, most agree that the cost increases in CSA are simply not sustainable in the long-term, regardless of the reasons behind the growth. Based on current trends, if the caseload growth and cost increases are not curbed, by FY 1998, the program will be serving over 17,000 at-risk children at a CSA program cost of approximately \$200 million. It should also be noted that Medicaid funds extensive inpatient and outpatient mental health services for CSA children (an estimated \$24.5 million in FY 1997).

One of the questions raised by these data is whether all of the children who benefit from CSA should actually be served through this program. The legislation for CSA clearly states that the program's resources should be used to serve those at-risk children whose needs require a level of services that can not be accommodated by the

referring agency. Further, because the decisions concerning whether a child has qualifying emotional or behavioral problems are largely subjective, there are legitimate questions about the type of children being served in CSA and whether they demonstrate problems that warrant the expenditure of program funds. This is one of the questions that will be examined in detail through this report.

STUDY MANDATE

In 1996, the General Assembly passed Senate Joint Resolution 123 directing JLARC to study the administration of the Comprehensive Services Act. This resolution requested that JLARC study the delivery of services in CSA, make recommendations to improve these services, and identify strategies for cost containment.

One year later, the General Assembly passed Senate Joint Resolution 371 amending the study parameters outlined in SJR 123. Among other things, this mandate requested that JLARC conduct a review of local CSA implementation practices for the purpose of identifying a set of best practices, clarify the issue of federal versus state service mandates, examine local utilization review practices, and assess the role and functions of the State agency responsible for providing technical assistance to local governments.

Finally, through Item 14J of the 1997 Appropriation Act, the General Assembly directed JLARC to focus on the management of CSA at the State level, assess local implementation of the program, conduct an analysis of the variation in the caseloads and unit costs of the program, and evaluate the effectiveness of CSA. Each of the study resolutions is included in Appendix A.

STUDY APPROACH

The unexpected growth in CSA expenditures has raised a number of unanswered questions about the management and operation of the program at the State and local level. Since the initial implementation of CSA, several studies have been completed on the operation of the program. However, these studies have either been limited in design or too narrow in scope to provide a reliable picture of CSA implementation. As a result, many of the key questions about the program remain unanswered.

Accordingly, and as directed by several mandates, JLARC's study of CSA focuses on the following areas: (1) the local implementation of CSA; (2) CSA caseload and participant cost trends; (3) an assessment of the effectiveness of CSA and whether program outcomes are consistent with the legislative intent; and (4) the State-level management of the CSA. Within these areas, the following issues are addressed:

- What impact has the CSA funding structure had on local implementation?

- How are CSA programs structured locally, who are the key participants, and what are their roles?
- What is the impact of local CSA eligibility and assessment policies, and are the policies and practices consistent with legislative intent?
- Are CSA placement decisions appropriate given the observed risks of the eligible participants?
- How are utilization review programs structured locally, and are these structures sufficient to ensure that quality services are being purchased?
- What factors appear to influence the changes in CSA caseloads statewide?
- What factors explain the local variation in the participant costs of the program?
- Are the treatment services funded for youths through the CSA program provided in the least restrictive environment, and does the cost of these services diminish over time?
- What types of adjustments do CSA participants make in school, at home, and in the community following the receipt of treatment services?
- Is the State-level structure of CSA adequate, and are the relevant entities effectively carrying out their duties?

Development of a CSA Participant-Level Database

Because there is no centralized, automated participant file for the CSA program, JLARC staff had to visit individual localities and review hard-copy records for a sample of their participants. Moreover, because one of the primary goals of the study is to determine what factors explain the existing variation in CSA unit cost, the sample would have to include a sufficient number of high and low cost localities.

To accomplish this, JLARC staff stratified all the localities in the State based on their FY 1995 unit costs. This fiscal year was chosen so that an 18 to 24 month period of follow-up would be available to track the progress of the CSA participants who were receiving services in this fiscal year. Next, the jurisdictions were organized into two strata: high unit cost and low unit cost. The cut-off point defining these strata was chosen based on the average unit cost observed across all localities. It was not feasible to visit all localities, but time and resources permitted JLARC staff to visit 22 localities. Therefore, once these strata were developed, the team selected 22 localities from across the State. These 22 localities are often referred to in this report as “the subset” of localities for this review. A disproportionate number of the localities that served the largest number of CSA participants was purposefully included in this sub-

set. As a result, the subset of localities accounted for approximately 51 percent of the children served and approximately 60 percent of CSA costs in FY 1995, according to data provided by the Office of Comprehensive Services.

To select the actual number of cases for review, JLARC staff generally decided that if a locality had more than 80 cases in FY 1995, a random sample of 80 cases would be chosen. If a locality had less than 80 cases in the FY 1995, each of the cases would be included in the sample. Based on this methodology, the team examined 1,144 of the 1,381 files that were targeted. This was about an 83 percent completion rate. Missing files, inadequate information, or time constraints were factors that affected the completion rate. Table 3 lists each locality in the sample and the number of files that were examined for that site. In calculating statistics based on the data collected, a weighting approach was used to account for the fact that different proportions of participants were included in the sample.

For each of the cases represented in the locally maintained files, JLARC staff collected the following data on most of the sample members:

- *demographics*: for example, race, gender, age, and educational level.
- *referring problem(s)*: for example, family dysfunction, emotional distress, behavioral problems, or aggressive behavior.
- *history of problems*: emotional problems, behavior problems, aggressive behavior.
- *criminal record*: number and nature of juvenile or adult criminal charges.
- *nature of the prescribed service*: for example whether foster care, special education, family therapy, health services, or a residential placement was provided; the costs of these services; and the length of time these services were rendered.
- *other social history data* needed for a risk assessment instrument, which is discussed in detail in Chapter III.

To ensure that the juvenile's criminal history was accurately measured, JLARC staff also surveyed each of the 35 court service units in the State, reviewed printouts from the Department of Corrections, and examined criminal reports from the State Police.

Local Implementation of CSA

Due to key changes created by the funding structure of CSA, questions persist about whether local governments have reduced their participation in the program, thereby reducing services for at-risk children who are considered "non-mandated" by

Table 3

Sample Size for Each Locality Included in JLARC's Study of CSA

| Locality | Youth Served In FY 1995 | JLARC Sample Size |
|---------------------------------------|----------------------------|----------------------|
| Low-Cost | | |
| Patrick County | 27 | 22 |
| Martinsville | 37 | 32 |
| Fredericksburg | 76 | 66 |
| Grayson County | 37 | 32 |
| Campbell County | 70 | 32 |
| Staunton | 76 | 73 |
| Hanover County | 111 | 53 |
| Nelson County | 21 | 19 |
| Norfolk | 811 | 72 |
| Hampton | 235 | 79 |
| Richmond | 1,042 | 65 |
| High-Cost | | |
| Virginia Beach | 569 | 73 |
| Henrico County | 262 | 75 |
| Dinwiddie County | 41 | 38 |
| Roanoke City | 435 | 71 |
| Montgomery County | 94 | 19 |
| Westmoreland County | 15 | 12 |
| Arlington County | 392 | 72 |
| Alexandria | 485 | 66 |
| Chesterfield County | 174 | 75 |
| Fairfax Co./Fairfax City/Falls Church | 1,214 | 77 |
| Shenandoah County | 21 | 21 |
| Totals | 6,245 | 1,144 |

Source: JLARC staff reviewed records from local school authorities, local welfare agencies, juvenile court service units, and local mental health agencies.

CSA law. More broadly, perhaps the largest unknown about CSA is how localities have decided to implement the program overall. The *Code of Virginia* gives local governments considerable discretion in deciding who will be served in CSA, what services will be funded, and how much providers will be reimbursed for the care they provide. Any key differences that exist across localities in how these decisions are made could have a substantial impact on the size and cost of local CSA programs. Therefore, for this part of the study, JLARC staff utilized the subset of 22 localities, and within these jurisdictions, randomly selected and reviewed participant files for 1,144 children who received services in FY 1995. Additional data were collected through structured interviews and mail surveys of key CSA staff in each of these localities as well as through a

review of provider files. Through the use of the structured interviews, JLARC staff identified some “best practices” that, if replicated statewide, could improve the operation of CSA (Appendix B).

Analysis of the Distinction Between Mandated and Non-Mandated CSA Youth. For this analysis, trends in the number of localities that provide funding for non-mandated cases as well as the amount allocated to services for these children were examined. Additionally, the team conducted a comparison analysis of children who were mandated to receive CSA services with those who are non-mandated, in order to determine the impact of this funding distinction on services to non-mandated at-risk youth. Finally, the team examined local policies utilized to bring non-mandated children into the sum-sufficient portion of the CSA fund pool.

Analysis of the CSA Assessment and Placement Process. Much of the individual data obtained through the file review was used to produce general profiles of the individuals served by CSA. This was done in order to evaluate the quality of the assessments that are made by each locality in the study. To accomplish this, the study team was trained in the use of an assessment tool developed by the director of the Mental Health Services Policy Program at Northwestern University. This tool, referred to as the Childhood Severity of Psychiatric Illness (CSPI), is used statewide by case-workers in Illinois’ mental health system to assess the dysfunctions of at-risk children (based upon symptoms documented in the child’s records) and evaluate their level of risk to themselves and others (Appendix C contains the CSPI). Information collected through the instrument has been shown to reliably predict service and clinical outcomes of those being rated.

An adapted version of the CSPI was utilized previously in Virginia for the purpose of generating CSA-youth profiles in a 1996 study commissioned by the CSA State Executive Council and conducted by the Commonwealth Institute for Child and Family Studies. The Commonwealth Institute used an adapted CSPI to facilitate the use of interviews for data collection. Because the JLARC staff study approach used case-file review as the data collection method, the CSPI as originally designed was appropriate for this activity. The substance of the CSPI and the adapted version utilized by the Commonwealth Institute are virtually identical. In administering this adapted version of the CSPI, the Commonwealth Institute trained graduate students in various disciplines to conduct the interviews. In many respects, the use of the adapted CSPI by the Commonwealth Institute, and the use of the actual CSPI by JLARC staff, found similar characteristics related to CSA.

Once a child’s risk was determined, JLARC staff used the CSPI and a set of prescribed decision rules or guidelines to identify the predicted or suggested placement for the child, such as a psychiatric hospital, residential treatment center, specialized foster care, or treatment through community outpatient services. These predicted or suggested placements were then compared to the actual decisions that were made for the child through the CSA referral and assessment process. Substantial mismatches between guideline suggestions and actual placements were given additional attention in the review.

Structured Interviews and Mail Surveys. As a supplement to the file reviews, JLARC staff conducted surveys of CSA case managers and interviewed the key local CSA officials who are involved in the implementation of CSA in each of the 22 jurisdictions that were studied. The mail surveys were sent to a sample of CSA case managers to develop an understanding of one aspect of utilization review under CSA — how local staff monitor the CSA providers for the cases which are assigned to their caseloads. The purpose of the interviews of local CSA officials was to determine what local policies have been established, how these stated policies differ from actual practices, and whether the policies and practices were consistent with legislative intent. Among the CSA staff that were interviewed were members of the policymaking management teams, the multi-agency assessment teams, the program fiscal agents and local CSA coordinators.

Review of Provider Files. A key issue in this study is whether service providers are delivering the services for which they are reimbursed. To address this issue, JLARC staff selected a subset of 75 CSA children from the sample who received services that cost at least \$5,000 in FY 1995. The providers of these services were asked to provide documentation of the treatment plans, progress notes, and outcomes of the treatment. JLARC staff reviewed this documentation to assess whether providers are developing appropriate care plans, performing appropriate interventions and discharge planning, and including the local CSA and families in their service plans.

CSA Caseload and Participant Cost Trends

Another of the basic aims of this study is to determine what factors appear to be driving the observed changes in CSA caseloads and the local variation in participant costs. On the issue of caseload growth, the study team collected statewide data on changes in the at-risk population and survey data on local implementation practices at all localities across the state. These factors were used in a multivariate model in an attempt to determine the extent to which they influenced statewide changes in CSA caseloads.

Because of the concerns expressed about the variation in unit costs across the various localities, a key aspect of the local implementation review was an assessment of the factors that appear to be associated with whether a locality has a high or low CSA unit cost. To conduct this analysis, the team collected data on factors that are both within and beyond the control of local CSA programs. These variables were constructed using data collected as a part of the aforementioned assessment of CSA local implementation practices and through the extensive file reviews in the subset of localities for youths who received CSA services in FY 1995. With these data, JLARC staff used regression analysis to identify those factors that help explain the reasons some CSA children experience higher participant costs than others.

Assessment of the Effectiveness of CSA

Presently, there is much uncertainty regarding the success that CSA has experienced in achieving two of its primary goals — preserving families and providing appropriate services in the least restrictive environment. These effectiveness issues were addressed through an analysis of participant files and a survey of the guardians of the children who received CSA services.

Participant and Service Data. Using data collected from files for a sample of youths and families who received CSA funded services in FY 1995, an assessment was made of whether and how CSA has changed the nature of services that at-risk youth now receive. Particular attention was given to whether CSA youths are being treated in less restrictive settings and whether the cost of this treatment has decreased over time.

VCU Telephone Survey. To address the issue of parental involvement in CSA — another legislative goal of the program — JLARC staff contracted with the Virginia Commonwealth University Survey Research Laboratory. The University's survey research staff contacted approximately 200 parents or guardians of children who received treatment services from CSA in FY 1995. Through the survey, the parents or guardians were queried on the following subjects:

- the level of their involvement in various aspects of the CSA service delivery system;
- their level of satisfaction with CSA service planning, service providers, and the local agencies involved in the CSA process; and
- the nature of their children's adjustment in various settings since they began receiving CSA services.

State-level Management of CSA

Clearly the architects of CSA envisioned a limited role for the State in the operation of CSA. However, concerns have been consistently expressed that the State has abdicated its leadership, management, and oversight roles for the program. This, some have argued, has allowed inefficiency and poor decisionmaking to establish a foothold in local service delivery practices.

JLARC staff examined the State-level management of CSA through the use of structured interviews with each member of the State Executive Council, State Management Team, and staff at the Office of Comprehensive Services. The focus of this review was on the following three areas: (1) the effectiveness of the State structure in monitoring CSA activities; (2) the level and quality of technical assistance provided by the Office of Comprehensive Services; and (3) the degree to which the State Executive

Council has developed the necessary policies to ensure that CSA is implemented in a cost-effective manner. In addition to reviewing all relevant documents and interviewing members of the various boards, JLARC staff attended meetings of both the Council and State Management Team.

REPORT ORGANIZATION

The remaining chapters in this report present the results of an analysis of the participant profile, costs, local implementation, and State-level management of the CSA program. Chapter II provides a brief analysis and description of the children who receive CSA funded services. Chapter III assesses the local implementation of the program. Chapter IV provides an analysis of the factors related to the CSA caseload and cost trends. Chapter V examines the outcomes associated with the CSA program. Chapter VI provides the results of JLARC's staff assessment of the State-level management of the program.

II. The Participants Served Through the Comprehensive Services Act

With the unabated growth in the caseloads for the Comprehensive Services Act, one issue that has been consistently raised is whether the program's resources are appropriately targeted to serve at-risk children. Although the legislation for the program includes prevention as a goal, CSA was primarily designed to serve troubled youth who continue to exhibit emotional or behavior problems that can not be addressed by any one human service agency.

While it is generally acknowledged that CSA dollars should be spent on prevention through early intervention programs for children, there is an emerging concern that the program has lost its intended focus. Critics of the program suggest that the wide discretion granted localities in applying CSA's eligibility criteria has opened the doors of the program to youths with only marginal risk. These decisions, they note, have driven up the costs of the program and weakened the system's capacity for addressing the needs of the severely dysfunctional child.

The first step in addressing this issue is to develop a profile of the children in CSA in terms of their family situations and their emotional and behavior problems. Presently, the lack of a statewide data system has limited the State's ability to analyze the characteristics of the children in CSA. Therefore, as a precursor to a more detailed assessment of both the program and its participants, this chapter sheds some light on whom CSA is serving and the nature and magnitude of their particular problems.

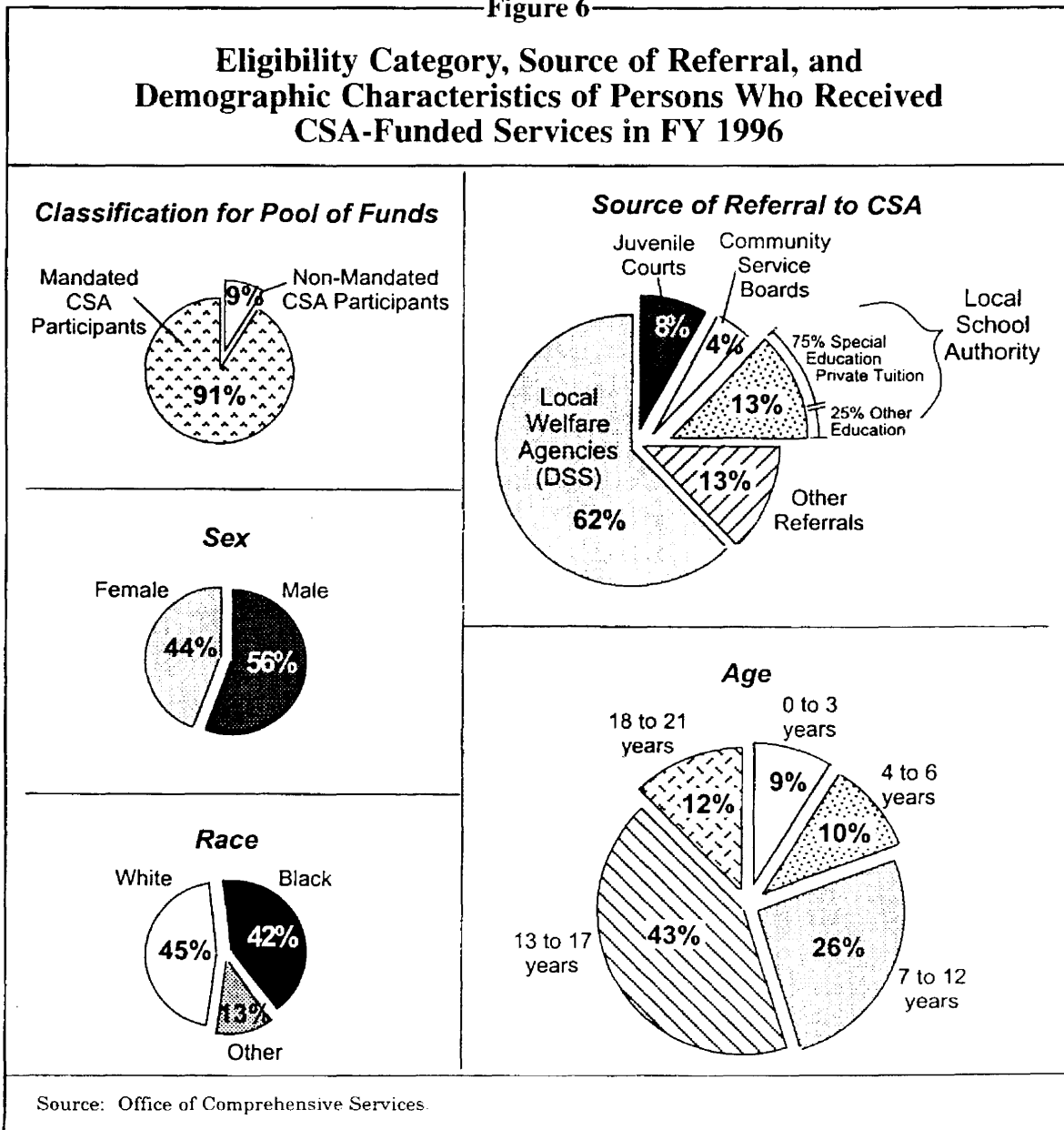
The findings indicate that the majority of the children in CSA have been reared in especially dysfunctional families in which they were either witnesses to, or subjects of, the cruelest forms of abuse and neglect. In these households, broken family structures, parental drug addiction and criminal behavior, and a heavy reliance on welfare, are often the norms. Most disturbing, approximately one in five of all of the children in the program have been sexually abused, typically by someone in their own family.

Although the dysfunction among the youths examined in this study was widespread, the related behavior problems were observed at much higher rates for two groups of CSA participants – youths who were referred from local education authorities and the juvenile court. Their counterparts, children in foster homes and those who established eligibility for the program through the "foster care prevention" provisions of CSA legislation, were considerably less likely to have symptoms of conduct disorder, oppositional behavior, emotional problems, or to require medication to control their behavior. Because these two groups account for the majority of the children in CSA, particular attention needs to be given to the type and cost of services they receive.

Most CSA Beneficiaries Are Mandated Recipients Who Come from Highly Dysfunctional Families

Much of what is known about the children in CSA has been determined from aggregate data collected by the Office of Comprehensive Services from each participating locality. According to data provided by this Office, Virginia's localities served more than 13,000 youth in CSA during FY 1996. An analysis of this data reveals the impact of CSA's mandated legislation, which gives preference to certain groups of at-risk children (Figure 6). As shown, more than nine out of every 10 youths who were served in

Figure 6



CSA in FY 1996 entered the program as a mandated case. Most of the CSA participants (62 percent) were referred to the program from local welfare agencies. Local school authorities were the second largest referral source for the program, accounting for approximately 13 percent of the referrals. Approximately three-quarters of the referrals for this group were for children who received tuition to attend private schools because of the problems they were having in the public school setting.

In terms of demographics, 56 percent of CSA participants were males. Racially, the differences in the proportion of whites and blacks in the program (45 percent to 42 percent) were minimal. Although children of any age are eligible for CSA services, most of the participants in the program are in the 13 to 17 year old age group (43 percent). Children between seven and 12 years of age constitute the second largest age group in the program (26 percent).

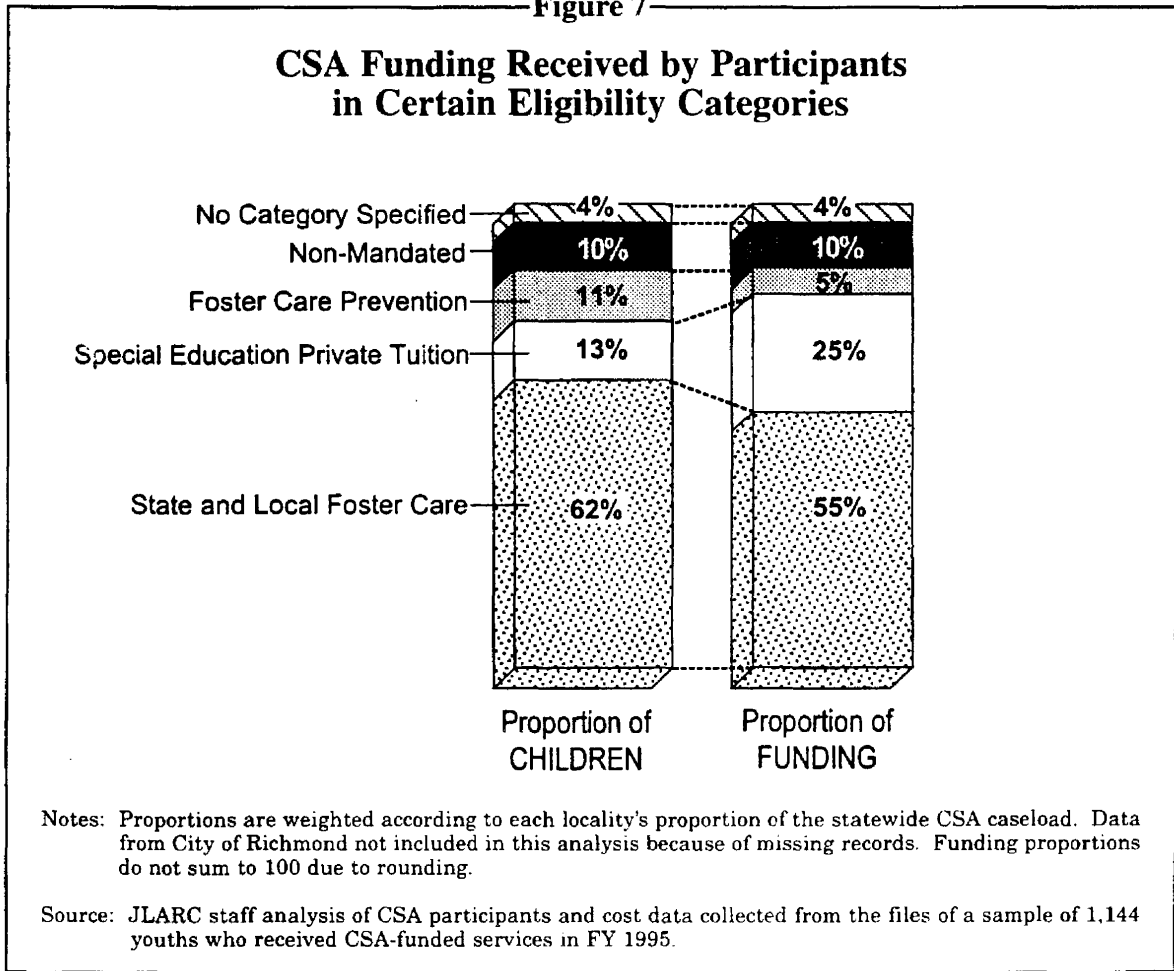
CSA Funding Received by Eligibility Category. This aggregate level data provides no information on the characteristics of the youths in CSA or their families or the cost of the services they received. To collect data of this nature, JLARC staff visited 22 localities and reviewed records for more than 1,100 randomly selected youths who, in FY 1995, were either receiving foster care services through CSA, or participating in treatment programs to address an identified need.

Figure 7 reveals how CSA funding is allocated among the various groups of participants who receive services through the program. As shown, children who established eligibility for CSA through the State and local foster care program — 62 percent of the study sample — received more than half (55 percent) of all CSA funding. Those youths who were mandated for services through the special education private tuition eligibility provisions of the statute (13 percent) received a disproportionate share of CSA funding based on their percentage of all CSA participants. Non-mandated children received CSA funds in amounts that were proportional to their representation in the program. Finally, approximately 11 percent of the youths in the sample established eligibility through the foster care prevention provisions of CSA. However, these youths received only five percent of the funding.

Problems Among CSA Participants. The problems in some of the families of these youths are summarized in Table 4. Overall, only 14 percent of the children in the sample lived with two parents at the time of their referral to the program. For children who established eligibility for CSA based on foster care, only 10 percent were living with both parents at the time of referral. More than half of the sample were from families who received public assistance from Medicaid, and from the Aid to Families with Dependent Children program (AFDC). Nearly two-thirds of the children in foster care were on welfare.

In terms of the specific dysfunction present in the families of these youths, approximately 55 percent of the children in CSA were from families where either one or both of their parents abused drugs. The lowest rate of parental substance abuse (32 percent) was observed for youths referred by the schools for special education services in private schools. For children in foster care, the rate was 62 percent. Somewhat

Figure 7



related to this is the fact that approximately 35 percent of the children in the sample had parents with criminal records, usually for drug-related offenses.

Perhaps most damaging to the children in CSA is the abuse they suffer at the hands of dysfunctional family members or friends. Three-quarters of the children in the JLARC sample were abused or neglected by their parents prior to their CSA referral. The rate of abuse for children prior to their placement in foster care was 90 percent. In the most egregious of abuse cases, 21 percent of the children in the sample were reportedly sexually molested or raped, typically by members of their families or close relatives. Statewide, this could mean that as many as 2,700 children in CSA have a reported history of sexual abuse.

The following case examples highlight the conditions under which some children in CSA have been forced to live.

* * *

Table 4

**Family Characteristics of CSA Participants
Who Received Services in FY 1995**

| Family Characteristics | Aggregated Average (Percent) | Category of Eligibility | | | |
|---|------------------------------|---|-----------------------|----------------------------------|------------------------|
| | | Special Education Private Tuition (Percent) | Foster Care (Percent) | Foster Care Prevention (Percent) | Non Mandated (Percent) |
| *Living With Both Parents | 14 | 28 | 10 | 15 | 19 |
| Medicaid Eligible | 68 | 36 | 76 | 51 | 62 |
| *Receiving AFDC | 58 | 27 | 66 | 42 | 57 |
| *Parents Abuse Drugs | 55 | 32 | 62 | 48 | 52 |
| *Parents Have Criminal Record | 35 | 22 | 39 | 26 | 23 |
| *Child Abused Prior To CSA Referral | 74 | 41 | 90 | 51 | 45 |
| Child Sexually Abused Prior To CSA Referral | 21 | 22 | 21 | 11 | 19 |
| Total Unweighted Cases | 1,144 | 144 | 721 | 106 | 99 |

Notes: Results reported in the table do not include information for 66 youths in the sample who were not placed in an eligibility category by CSA staff. The reported sample proportions are weighted based on the localities' proportion of total CSA caseload. With a few exceptions, all foster care children are eligible for Medicaid. The difference in this table reflects the fact that some children were placed in foster care after FY 1995. Asterisks in front of family characteristics indicate that the differences are significant at a 5 percent level of significance, based on chi-square statistics. Missing data are not included in the calculation of statistics.

Source: JLARC staff analysis of records reviewed in 22 localities from the local welfare, mental health, education, and juvenile court agencies.

In 1991, two youths, referred to as "Jimmy" and "Larry", were placed in foster homes by the local welfare agency in their county. Jimmy and Larry were removed from their home because of the long-term physical and sexual abuse that they experienced at the hands of their biological parents.

By all indications, Jimmy and Larry's parents forced them to live in a chaotic, dysfunctional, and extremely harmful environment. Just prior to 1990, their mother, a chronic alcoholic, left their father and took Jimmy and Larry with her. At the time, the children were 5 and 6 years of age. While in her custody, the children were first forced by their mother to watch her in sexual encounters with numerous men. After some time, the mother forced both children to participate in these sexual encounters.

Upon learning of these activities, the children's father removed them from this environment only to expose them to similar acts of sexual abuse in his home. Both children were raped and sodomized by their father and several of his co-workers. In addition to this abuse, the father disciplined the children in the following ways: he forced their heads into the toilet and flushed it to create a "sensation of drowning"; he forced their heads into garbage cans; and he tied them up with chains and would hang them from the ceiling by their arms and necks.

Under threats of death, both children were ordered to keep quiet about the abuse. In addition, their father refused to allow one of his children to have surgery on his tongue to correct a severe speech impairment. According to the social history report, this was probably done to ensure that this child would not be able to discuss the abuse that he suffered.

Initially, in 1993, both Jimmy and Larry were placed in foster care and received no other CSA-funded services. However, because of their profound behavior problems, the CSA multi-agency team placed one of the children in intensive counseling and the other in a residential group home.

* * *

"Mary," who is now 14 years of age, has been in foster care since the fall of 1986. At that time, Mary was removed from her home after her parents were incarcerated on charges of beating one of her brothers to death. Mary was one of 13 children, many with emotional and behavioral problems, who had been adopted by "John" and "Anne" "Smith." The Smiths also had four biological children of their own. The Smiths and all 17 of their children lived an itinerant lifestyle, traveling around the country on a converted 38-foot school bus. The bus, it was later determined, had inadequate heating and bathroom facilities. The Smith children were not enrolled in school and received little or no health care.

The Smiths had rigid religious beliefs that stressed the need for children to obey their parents. When the children acted out, the Smiths resorted to increasingly harsh and bizarre forms of punishment over a five-year period. For one child, "Michael", the punishment included being shackled naked to the floor of the school bus, not being fed for up to four days at a time, and being forced to eat his own feces and drink his own urine. He was also beaten severely with a wooden paddle. Often Anne Smith would beat the child with the paddle while her husband revved the engine on the school bus in order to drown out the sound of the child's screams.

After a particularly severe beating, Michael was taken to a local hospital and died a few days later. John and Anne Smith were convicted on a variety of charges in connection with Michael's death, including first-degree murder, involuntary manslaughter, kidnapping, child neglect, and assault, and were sentenced to 41 and 31 years in prison, respectively.

Although none of the other Smith children were abused as severely as Michael, they all were physically abused. Also, they suffered emotional abuse from witnessing their brother's torturous upbringing. At a court hearing two years later to terminate the Smiths' parental rights, some of the children testified that they could still hear Michael's screams. All of the children are now in the CSA funded foster care program.

* * *

Two siblings in the sample, now ages 11 and 14, first came to the attention of the local welfare agency in their county 10 years ago. A protective services worker entered the residence of the "Walters" to investigate charges that the parents were abusing and neglecting seven children. At the time of her arrival, the worker found the children ranging in age from 4 months to 11 years to be without adult supervision. The Walters could not be located and the children had no knowledge of how to contact them.

The house was extremely filthy, unsanitary, and cluttered. The floors were covered with trash and dangerous items such as hooks and tacks. Knives were left within easy reach of the children. A "tremendous" number of beer cans were found lying on the floor throughout the house along with dried food that had been obviously sitting for days. At one point during the visit, a large rat emerged from garbage strewn beneath the house.

The children were filthy and they all had bad cases of head lice. One child was outside completely naked. The one year old child was asleep with no diaper, dried feces on his body, and had swarms of flies all around him.

Since that time, two additional abuse and neglect petitions were filed against the Walters family in the early 1990s and the children were subsequently removed from the home and the parents were ordered into parenting classes which were paid for by CSA.

* * *

“John” was referred to CSA by the juvenile court in April of 1994. At the time of his referral, John was 14 years of age, was the product of a severely dysfunctional family, had lived a traumatic life, and had a serious criminal record. The social history report on John indicated that he was kidnapped by his father at age 4. For eight years, he lived on the run with his father, until he was abandoned at the North Carolina Department of Social Services. More significantly, during these eight years, John was repeatedly raped and physically abused by his father. Medically, he has tested positive for numerous head traumas which may have been the result of physical abuse.

When John was finally returned to his mother, his living conditions only marginally improved. His mother was in poor health with cancer of the brain, liver, and pancreas. In addition, the social history reports that her parenting skills were negligible due mostly to her family background which was characterized by chronic alcoholic parents, extensive drug use, court involvement, and serious physical abuse. At the time John was returned to his mother, she was living in an apartment with no furniture. All of the members of the household – John, his mother, aunt, and sister – slept on the floor. Unable to work because of her illness, John’s mother relied on SSI, and AFDC payments for support. Her total income from these sources was \$9,540 a year.

Due undoubtedly to these types of conditions, significant behavior problems were observed for each eligible group of CSA participants. However, these problems are clearly present in higher levels among youths who were in the non-mandated category and those who established eligibility as special education private tuition assistance cases (Table 5).

At an average age of 10, more than half of the children in the sample displayed emotional problems. This included children who were suffering with mild to severe levels of depression. As a result, some of these children experienced impairments in their ability to function in school, with peers, or in their family. Among those who established eligibility for CSA through the provisions for private tuition special education, 86 percent had emotional problems. The rate for non-mandated children was almost as high, at 79 percent. By comparison, less than half of the children in the foster care (48 percent) and foster care prevention categories (46 percent) had these problems.

Slightly more than 40 percent of the sample displayed symptoms of conduct disorder. As defined by the risk assessment instrument used by JLARC staff, children with problems in this area generally were truants, were involved in petty thefts, displayed mild to severe planned episodes of aggressive behavior, and were often involved in acts of vandalism. These problems were most prevalent and generally the most acute among the older non-mandated children (65 percent). Comparatively, only a

Table 5

**Problems Observed Among CSA Participants
Who Received Services in FY 1996**

| Characteristics | Aggregated Average | Category of Eligibility | | | |
|--|--------------------|-----------------------------------|-------------|------------------------|--------------|
| | | Special Education Private Tuition | Foster Care | Foster Care Prevention | Non Mandated |
| Average Age | 10.9 | 13.1 | 9.4 | 9.8 | 13.8 |
| Child Had Emotional Problems At Referral | 56% | 86% | 48% | 46% | 79% |
| Child Suffered From Conduct Disorder | 41% | 57% | 33% | 41% | 65% |
| Child Described As Oppositional | 47% | 76% | 35% | 48% | 73% |
| Child Had Impulse Control Problems | 45% | 76% | 36% | 44% | 66% |
| Child Had Neuro-Psychiatric Problems | 14% | 38% | 9% | 5% | 21% |
| Child On Psychotropic Medication | 32% | 69% | 24% | 25% | 43% |
| Child Had Juvenile Criminal Record At Time Of Referral | 10% | 4% | 6% | 17% | 29% |
| Total Unweighted Cases | 1,144 | 144 | 721 | 114 | 99 |

Notes: Results reported in the table do not include information for 67 youths in the sample who were not classified in an eligibility category by CSA staff. The sample proportions are weighted based on the localities' proportion of total CSA caseload. For all of the characteristics, differences reported in the table are significant at a 5 percent level of significance. Missing data are not included in calculation of statistics.

Source: JLARC staff analysis of records reviewed in 22 localities from the local welfare, mental health, education, and juvenile court agencies.

third of CSA's foster care cases displayed symptoms of conduct disorder at the time of referral to the program.

Approximately 45 percent of the sample had what are described as impulse control problems (for example, hyperactivity, failure to pay attention or follow instructions, an inability to concentrate on tasks, or running at inappropriate times). When diagnosed as impulsive, the children in the study sample were often medicated to mitigate the impact of this disorder on their behavior.

A much smaller percentage of the children in CSA (14 percent) had the more serious diagnosis of neuropsychiatric problems. These disturbances, which include schizophrenia, psychotic disorders, delusions, strange speech, and hallucinations, were most prevalent among children in private special education programs (38 percent). Accordingly, almost 70 percent of this group were on some type of psychotropic medication for various emotional disturbances or disorders at the time they entered CSA. This was more than twice the rate observed for the entire sample.

Only a small percentage of CSA children had criminal records at the time of referral to the program (10 percent). As expected, this problem was most frequently observed for the non-mandated population, most of whom are typically referred from the juvenile courts. Almost three in ten of this group had a criminal record.

While not conclusive, the characteristics data presented in this chapter address a number of questions about the participants in the program. Irrespective of their route to CSA, most come from broken homes where they are subject to chaotic upbringings and almost unspeakable abuses. Many of these youths demonstrate a range of problems that are to be expected for children in these types of environments. However, there are also some youths in the program whose problems are relatively less severe.

This raises a host of other questions. For example, at the time that they are referred to CSA, what proportion of youths appear to be a minimal risk to themselves or society? What impact do these groups have on the rate of caseload growth in CSA? What types of services are provided to these youths and how do they compare to those with much higher risk? Can cost savings for the program be realized by tightening CSA eligibility policies without denying services to significant numbers of children with serious risks? These are the types of questions that are addressed in the remainder of this report.

III. Local Implementation and Monitoring of CSA

Since the initial implementation of CSA in 1993, several studies have been completed on the operation of the program. While this research has provided State officials with some general information on the approaches used by local governments to target CSA-funded services on at-risk children, most of these studies have either been limited in design or too narrow in scope to provide a reliable picture of CSA implementation. The lack of data on the program at the local level, combined with the broad discretion localities have in operating CSA, has raised concerns about how the program is implemented locally. Further, a number of policy proposals to address what has been described as the escalating cost of CSA have been held in abeyance until a more systematic review of CSA could be completed.

This chapter presents the results of JLARC staff's comprehensive review of the local implementation of CSA. To conduct this analysis, JLARC staff examined local practices associated with eligibility determination, the CSA assessment process, and local utilization review plans.

The findings from this review indicate that while there are some significant problems with the way CSA is being implemented locally which do have cost implications, achieving savings in the aggregate cost of the program will be difficult without making policy decisions to limit the extent to which children with needs are served. Currently, many localities are containing costs under CSA by refusing to serve children who are not "mandated" under current law. In most cases, however, the emotional and behavioral problems of children who are considered "non-mandated" are similar, and in some cases, greater than those of children for whom services are "mandated."

Apart from the issue of which children get services through CSA, there appear to be opportunities to improve both the efficiency of the program and the degree to which CSA meets legislative intent. While some localities are operating CSA in a manner that reflects the goals of the legislation, in other cases it appears that local governments have not fully embraced the legislative intent for the program. The statute places an emphasis on serving children with serious emotional and behavioral problems, and as documented in Chapter II, many CSA children have serious problems. However, almost half of the children who received treatment services through CSA in FY 1995 either had no risk or only a history of risk of serious behavior (they did not pose a danger to themselves or others, and were not a threat to run away). While many of these youths had symptoms which suggest the need for some treatment, the lower levels of risk indicate that these children pose less of a risk to themselves and society, and therefore these cases may be easier to manage. Some of these children were provided services through early intervention initiatives of local programs, while others received basic social services under the foster care prevention designation of CSA. Accordingly, there is a question of whether CSA should be the vehicle for these types of services.

Moreover, in many cases, children were given access to CSA by local staff who routinely circumvented the eligibility and screening process envisioned by CSA statute. While this process is not fully mandated in all cases, the extent to which it is currently bypassed undermines the intent of the Act to use a multi-agency approach. More damaging to the integrity of CSA are the actions of CSA staff in half of the localities included in the study, who admit that they manipulate the system to establish eligibility for children who do not meet the requirements of certain provisions of the statute as a method of getting them services. In other localities, CSA staff are misclassifying children as “mandated” who would not have received services but for these decisions.

Once children gain access to CSA, the evidence from this study indicates that local staff placed the children in appropriate treatment settings in about half of the cases. For 15 percent of the cases, children may have received a higher level of service than appears justified by their risk, and in 35 percent of the cases children may have received a lower level of service than appears justified by their risk. Also, once the placement process is complete, local CSA staff typically do not engage in a systematic review of the services and can therefore not be certain that the appropriate treatment was provided in the most cost-effective manner.

IMPACT OF CSA FUNDING STRUCTURE ON LOCAL IMPLEMENTATION

A major criticism of the Comprehensive Services Act has been the distinction it draws between “mandated” and “non-mandated” youth. Sum-sufficient language in the Act guarantees that mandated youth, primarily children in foster care and special education students who need a private school placement, must receive any treatment services which they are determined to need. Non-mandated youth — primarily juvenile offenders and children with mental health problems — are not covered by sum-sufficient language and are only served at the discretion of individual localities. This distinction, it has been argued, runs counter to the CSA’s intent to eliminate categorical distinctions among at-risk youth and artificially distinguishes between children with similar emotional and behavioral problems.

JLARC first examined this issue in 1995, when only one complete year of CSA data were available. The findings presented in the current analysis are consistent with JLARC’s conclusions in 1995, and they support many of the criticisms of this aspect of the program. Faced with the costs of serving larger numbers of mandated CSA participants, more than a third of all localities in the State continue to exercise their options to spend no CSA money on at-risk children who are considered non-mandated. Another 24 percent spend less than one-quarter of their CSA protected level for non-mandated children. As a result of these decisions, the total amount of spending on non-mandated youth has declined by six percent since FY 1993 — the last year the State used categorical funding under the system that preceded CSA. The problem with this is that the savings are not being achieved based on a rational policy that differentiates between the needs of the children.

Distinction Between Mandated and Non-Mandated Children Has Posed Problems for Local Implementation

As discussed in Chapter I of this report, CSA's eligibility criteria and funding structure draws distinctions among the youth in need of services as mandated for services or non-mandated for services. Because of this funding structure and accompanying eligibility criteria, localities often must choose between diminishing their available CSA funds by serving non-mandated children or providing little or no services to this group of children. The mandated/non-mandated distinction has resulted in reductions in local expenditures for non-mandated youth despite similarities between the two groups in terms of their dysfunctions. Furthermore, the distinction has produced an incentive on the part of local CSA officials to find ways to mis-classify non-mandated children as mandated in order to access CSA services.

Local Expenditures on Non-Mandated Youth. The new CSA funding structure, which is outlined in detail in Chapter I, did not significantly alter the overall funding responsibilities of the State and local governments for at-risk youth that existed prior to CSA (Table 6). In the last year before CSA was established, the State's share of the cost of services for at-risk youth was 60.9 percent and the local share was 39.1 percent. After the new funding structure was implemented, the State's share rose slightly to 61.2 percent, with a commensurate drop in the local share to 38.8 percent. Since then, the State's share has continued to rise slightly, reaching 62.7 percent in FY 1996. However, the CSA funding structure did alter the funding responsibilities for mandated and non-mandated children. Prior to CSA, localities were responsible for 44 percent of the expenditures for mandated services (Table 7) and none of the costs of non-mandated services (Table 8). This reflected the fact that pre-CSA funding streams for mandated services often required local matching funds, while funding streams for non-mandated services did not. CSA ended this practice by requiring that localities match all State funds. Consequently, the localities' share of mandated expenses fell slightly in FY1994 from 44 to 39 percent, while their responsibility for non-mandated services increased sharply from zero to 39 percent.

Table 6

Expenditures for Both Mandated and Non-Mandated CSA Services

| | <i>FY 1993</i> | <i>FY 1994</i> | <i>FY 1995</i> | <i>FY 1996</i> |
|-------------|-----------------------|-----------------------|-----------------------|-----------------------|
| State Cost | \$54,243,312 | \$63,946,918 | \$78,367,148 | \$90,687,847 |
| State Share | 60.9% | 61.2% | 62.1% | 62.7% |
| Local Cost | \$34,859,344 | \$40,607,967 | \$47,790,394 | \$53,984,309 |
| Local Share | 39.1% | 38.8% | 37.9% | 37.3% |
| Total Cost | \$89,102,656 | \$104,554,885 | \$126,157,542 | \$144,672,156 |

Source: The Department of Education and Office of Comprehensive Services.

Table 7

Expenditures for Mandated CSA Services

| | <i>FY 1993</i> | <i>FY 1994</i> | <i>FY 1995</i> | <i>FY 1996</i> |
|-------------------|---------------------|---------------------|----------------------|----------------------|
| State Cost | \$44,001,195 | \$57,823,139 | \$72,268,557 | \$84,636,884 |
| State Share | 55.8% | 61.2% | 62.1% | 62.7% |
| Local Cost | \$34,859,344 | \$36,719,207 | \$44,071,273 | \$50,382,259 |
| Local Share | 44.2% | 38.8% | 37.9% | 37.3% |
| Total Cost | \$78,860,539 | \$94,542,346 | \$116,339,830 | \$135,019,143 |

Source: The Department of Education and Office of Comprehensive Services

Table 8

Expenditures for Non-Mandated CSA Services

| | <i>FY 1993</i> | <i>FY 1994</i> | <i>FY 1995</i> | <i>FY 1996</i> |
|-------------------|---------------------|---------------------|--------------------|--------------------|
| State Cost | \$10,242,117 | \$6,123,779 | \$6,098,617 | \$6,045,023 |
| State Share | 100% | 61.2% | 62.1% | 62.7% |
| Local Cost | \$0 | \$3,888,760 | \$3,719,097 | \$3,598,453 |
| Local Share | 0% | 38.8% | 37.9% | 37.3% |
| Total Cost | \$10,242,117 | \$10,012,539 | \$9,817,714 | \$9,643,476 |

Source: The Department of Education and Office of Comprehensive Services.

In response to these changes in the funding structure, combined with substantial increases in CSA costs, it appears that localities are reducing services to non-mandated youth. The State has tried to encourage localities to provide non-mandated services by allowing them to protect a certain level of their CSA funds for these services. The State determines each locality's "protection level" by setting aside 12 percent of the year's State and local CSA appropriation and then allocating this amount among localities using shares from the growth allocation formula. When the CSA State pool of funds was created in FY 1993, the non-mandated funding streams represented 12 percent of the total. These funds are "protected" because localities do not have to expend them before requesting supplemental funds to cover mandated services. However, these protection levels are voluntary and localities are not required to spend any funds on non-mandated youth.

An examination of locality spending patterns on non-mandated youth in FY 1996 indicates that localities typically spend much less than their allotted protection level on non-mandated services (Table 9). Moreover, these figures are largely unchanged

Table 9

**Percentage of FY 1996 Protection Level Expended
by Localities for Non-Mandated Youth**

| Percent of Protection Level Expended | Percent of Localities in Range FY '95 | Percent of Localities in Range FY '96 |
|--|---|---|
| 0 percent | 35 | 34 percent |
| 1 percent – 25 percent | 20 | 24 percent |
| 26 percent – 50 percent | 12 | 11 percent |
| 51 percent – 75 percent | 14 | 11 percent |
| 76 percent – 99 percent | 8 | 10 percent |
| 100 percent or more | 11 | 11 percent |

Source: JLARC staff analysis of expenditure data provided by the Department of Education.

from FY 1995 – the first year JLARC examined this issue. In FY 1996, a total of 45 localities — more than a third of all localities in the State — spent nothing on non-mandated services in FY 1996, and an additional 24 percent spent less than a quarter of their protection level. Only 11 percent of Virginia localities spent 100 percent or more of their protection level. Localities that do not spend funds on non-mandated youth appear to be located primarily in rural areas of the State such as Southwest Virginia, the Shenandoah Valley, the Middle Peninsula, the Northern Neck, and Southside Virginia (Figure 8).

As part of the JLARC survey of local CSA implementation practices, localities that did not spend funds on non-mandated youth were asked to give the major reason for their decision. Almost unanimously, those localities cited the fiscal strain caused by rapidly rising CSA costs and the obligation to first provide services to mandated children. Consequently, many youth who have emotional or behavioral problems but are not mandated for CSA services are simply never referred to the local programs. For some of those who are referred to CSA but turned down, an attempt is often made to find counseling services in the community that may be supported through other funds.

Given this problem with serving non-mandated youth, it is not surprising that since FY 1993, the last year under the old system, the total amount of CSA spending on this population has declined in both absolute and relative terms. Actual spending has declined by approximately \$600,000 (Table 10) during the FY 1993 to FY 1996 time period, and non-mandated spending as a share of total CSA spending has dropped from 11.5 percent to 6.7 percent.

Characteristics of Mandated and Non-Mandated Youth. As a part of the analysis of this issue, JLARC staff compared the mandated and non-mandated youth in its sample of more than 1,100 CSA cases to determine the extent to which the two

Table 10

Spending on Non-Mandated Youth Has Declined

| Fiscal Year | Total CSA Spending | Non-Mandated Expenditures | |
|-------------|--------------------|---------------------------|------------------|
| | | Dollars | Percent of Total |
| 1993 | \$89,102,656 | \$10,242,117 | 11.5 percent |
| 1994 | \$104,554,885 | \$10,012,539 | 9.6 percent |
| 1995 | \$126,157,544 | \$9,817,714 | 7.8 percent |
| 1996 | \$144,662,619 | \$9,643,476 | 6.7 percent |

Source: JLARC staff analysis of expenditure data provided by the Department of Education.

categories of at-risk youth have similar characteristics. Note that this analysis includes only those non-mandated youth who received a CSA-funded service in FY 1995. This approach excludes some other types of non-mandated youth, such as those who were not referred to a CSA multi-agency team at all, or those who did appear before a team but did not receive a CSA-funded service. However, since these youths are generally turned away from CSA for funding reasons and not for issues related to their treatment needs, it is reasonable to assume that the non-mandated youths who gain access to CSA have similar characteristics to those who do not.

As shown in Table 11, when compared to mandated youth, a higher percentage of the non-mandated children in the JLARC sample were white males. Non-mandated youth were also almost two years older than mandated youth at the time they first received a CSA-funded services other than regular foster care. However, mandated youth were much more likely to have been abused (71 percent to 42 percent) and sexually abused (28 percent to 16 percent) prior to their CSA referral.

In terms of criminal behavior, a higher proportion of non-mandated youth posed greater risks. Specifically, 33 percent of non-mandated youth and 10 percent of mandated youth had a criminal record prior to receiving CSA-funded services. For those youth with a criminal record, non-mandated youth were more likely to have had a felony as their most serious offense (67 percent to 34 percent), while mandated youth were more likely to have a misdemeanor as their most serious offense (49 percent to 13 percent).

With respect to the other problems that will typically trigger a referral for CSA services, the two groups of participants were generally similar. Specifically, there were no statistically significant differences in the proportion of mandated youth that were diagnosed with conduct disorder or impulse control problems. However, a higher proportion of non-mandated youth were diagnosed with oppositional disturbance. Mandated youth were almost twice as likely to have a diagnosed psychiatric disorder (13 to eight percent), but this difference was not statistically significant. Finally, there

Table 11

**Characteristics of Mandated and Non-Mandated Children
Receiving a CSA-Funded Service in FY 1995**

| Characteristics | Mandated | Non-Mandated |
|--|-----------------|---------------------|
| *Sex | | |
| Male | 56 percent | 73 percent |
| Female | 44 percent | 26 percent |
| Race | | |
| White | 45 percent | 50 percent |
| Black | 43 percent | 42 percent |
| Other | 11 percent | 7 percent |
| Average Age | 12.2 years | 13.6 years |
| *Child Abused Prior to CSA Referral | 71 percent | 42 percent |
| *Child Sexually Abused Prior to CSA Referral | 28 percent | 16 percent |
| *Child Has Criminal Record | 10 percent | 33 percent |
| *Most Serious Prior Offense | | |
| Violent Felony | 21 percent | 32 percent |
| Other Felony | 14 percent | 35 percent |
| Misdemeanor Against Person | 29 percent | 1 percent |
| Other Misdemeanor | 20 percent | 12 percent |
| Violation of Court Order | 1 percent | 16 percent |
| Status Offense | 13 percent | 4 percent |
| Clinically Diagnosed Problems | | |
| Psychiatric Disorders | 13 percent | 8 percent |
| Emotional Disturbance | 50 percent | 56 percent |
| Conduct Disorder | 34 percent | 41 percent |
| *Oppositional Disturbance | 39 percent | 50 percent |
| Impulse Control Problems | 43 percent | 45 percent |
| Receiving Psychotropic Medication | 44 percent | 36 percent |
| CSA Dollars Received in FY 1995 Per Day of Care | | |
| Median | \$41 | \$27 |

Notes: The reported frequencies are weighted based according to each locality's proportion of the total CSA caseload. *Chi-square statistic indicates that differences are significant at a .05 level of significance.

Source: JLARC staff analysis of data collected from the 22 localities, 35 court service districts, the Department of Corrections, and the Virginia State Police.

was no statistically significant difference in the proportions of both groups of youths receiving psychotropic medication at the time of their referral to CSA for treatment.

In summary, while some differences do exist across these two groups of CSA participants, these findings suggest that the emotional and behavioral problems for the non-mandated youth in CSA are about as serious as those of the mandated children. Despite this, JLARC staff found significant differences in the amounts that were spent on the treatment for mandated and non-mandated in FY 1995. As shown in the Table 11, the median for dollars spent per day of care in FY 1995 for the mandated population was \$41. This was 59 percent greater than the median amount spent for the non-mandated group. Thus it appears that the remaining categorical distinctions in CSA not only reduce the likelihood that one group of at-risk children will receive services through the program, but they may also reduce the amount of dollars that localities spend on treatment services for this group, irrespective of their diagnosed symptoms.

It has been suggested that localities can use funds from the Virginia Juvenile Justice Crime Control Act to mitigate the access problems for non-mandated children created by CSA's funding structure. A study of how localities are using the funds from this recently enacted legislation is presently under way. However, the preliminary findings suggest that the services funded through this legislation are not clinically-based. Instead, they are being used in accordance with the intent of the Crime Control Act, which is to establish a community-based system of progressive sanctions.

Recommendation (1). The General Assembly may wish to amend the *Code of Virginia* to require that non-mandated cases, where children have displayed acute or recent risk, be afforded sum sufficient funding. In order to access sum sufficient funding for these cases, local CSA multi-agency teams should be required to make these risk determinations through a uniform assessment process. This recommendation is contingent upon the General Assembly's approval of Medicaid as an alternative funding source for CSA.

Service Selection for Non-Mandated Youth. In 50 percent of the localities visited by JLARC staff, CSA personnel indicated that they sometimes manipulate the system to get around what are perceived as ambiguous or restrictive eligibility criteria. This is done to ensure that children get services, and is sometimes accomplished by "making a child fit" into a specific mandated eligibility category or using the mandated foster care prevention category to access services. For example:

In one locality, program staff stated that sometimes it is difficult to provide needy children with CSA services based on "restrictive" eligibility criteria. The multi-agency team members indicated that often they must be resourceful in making eligibility determinations. In one instance, a multi-agency team member indicated that after running out of methods to bring a youth into CSA services, the team proceeded with trying to see what charges they could "drum up" on the youth in

order to access services. Charges were initiated and the youth received CSA services.

* * *

Local leadership in another locality questioned the costs of its CSA program. Specifically, the use of foster care prevention determinations to purchase CSA services were in question. In order to control CSA costs, the local leadership instituted cost avoidance measures such as discontinuing non-mandated funded services and refusing to approve other questionable service determinations. Multi-agency team members upset with these strategies suggested to JLARC staff that they could "find ways to make children mandated" or "find ways to access CSA funds through foster care prevention." One team member added that if local leadership pushed them too far, they would begin "making children mandated" for CSA services.

Multi-agency team members frequently suggest that strategies such as those mentioned above are necessary because their local governments make no provisions to serve children who are not mandated by CSA, notwithstanding the actual treatment needs of this population. As children who are labeled "foster care prevention" are mandated to receive CSA services, this vehicle is often used to access CSA funds when professionals involved with service determinations believe that it is in the best interest of the child to remain with his or her family. However, because the range of services that can be purchased through foster care prevention determination have no statutory limitations, these determinations have often resulted in local governments questioning the use of these funds. The following comments by a State DSS official regarding the use of foster care prevention services underscores the ambiguity associated with this issue.

There is no federal or state definition of what constitutes a foster care prevention service. However, the general rule is that any hard or soft service that can reasonably be expected to allow a child to remain with his or her family (in the absence of abuse and/or other threatening situations) should be allowable as long as it is cost effective and limited in duration. As the old saying goes, "An ounce of prevention is worth a pound of cure." In reality, a small expenditure up front to a family with one or more children at risk usually results in the children remaining with the family and avoiding a long-term expenditure resulting from placement into a home or residential facility. We feel it is critical to provide continued flexibility for the local agencies and our policies will continue to promote this position.

However, this flexibility has not come without some abuse. For example:

In one locality, although a child was receiving behavioral management incentives related to his special education program, the local CSA unit was purchasing these incentives through a foster care pre-

vention determination. When a request for an extension of this foster care prevention service was reviewed by a DSS regional supervisor, as required by the Code of Virginia, the DSS agent, reviewing this service determination for the first time, refused to grant the extension. The DSS agent indicated that the service should not have been paid through a foster care prevention determination at the outset. The service provided was "part of an overall classroom strategy for behavior management...and did not appear to meet CSA guidelines as a foster care prevention service...." Rather the services provided should have been paid through resources other than the sum sufficient foster care prevention funds.

* * *

In another locality, Office of Comprehensive Services staff were called upon to review the locality's extensive use of foster care prevention determinations. Although the review found that, for the most part, the locality had provided services appropriately under the broad discretion which foster care prevention determinations allow, a few determinations were questionable. These determinations involved in part services provided to adults where there was no clear connection to a child. This is significant because all CSA service determinations must be child-related.

Sixty-eight percent of the localities in the subset of localities reviewed for this study treated children who receive special education services, but not private tuition assistance, as mandated — in direct violation of State law. The State Executive Council approved this policy in an effort to allow less costly and less restrictive services within public schools. However, these determinations permit localities to spend CSA funds for services as a result of eligibility misclassifications. An issue of concern is how certain eligibility determination practices impact the magnitude of children coming into the CSA program. Substantial differences in these practices could result in some localities serving a much larger proportion of at-risk children than others. However, it also creates the possibility that large numbers of children who have minimal risk will gain access to CSA-funded services.

CSA LOCAL ELIGIBILITY AND CLIENT ASSESSMENT PRACTICES

One of the unique features of CSA is the flexibility that the *Code of Virginia* provides localities in establishing local CSA programs. For example, there are few legal requirements for how CSA participants are to be assessed and what services they are to receive. Still, certain parameters do exist in which CSA programs must operate. For example, the *Code of Virginia* identifies key local CSA participants, which include community policy and management team members (CPMT), multi-agency team members, and a designated fiscal agent. The *Code* also identifies the duties of these key

participants as well as criteria for providing services to the eligible population of children and families.

Clearly in the subset of localities under review, these required multi-agency teams were in place, and almost without exception, the required policies were committed to writing. Moreover, in an attempt to more effectively operate CSA programs, localities had instituted additional multi-agency teams and program staff. Usually these teams or staff pre-screened potential CSA eligibility cases, conducted mid-level management reviews of proposed services, or coordinated CSA program activities.

However, for a number of CSA-funded services, JLARC staff found that local program participants have chosen to frequently bypass the collaborative process which was envisioned by CSA legislation. Many local program staff regard the multi-agency review as a cumbersome process to be avoided. In addition, some localities have established dollar thresholds for service determinations whereby case managers may bypass the multi-agency process. Still, other localities have designated that only certain CSA-funded services, such as residential care, must go through the multi-agency process. Because these unilateral assessment decisions do not reflect the intent of CSA legislation and may result in inappropriate placements, the cost effectiveness of CSA has been questioned.

Additionally, JLARC staff found that there is no uniform screening and assessment process for children attempting to access CSA services. The lack of a uniform screening and assessment process has been identified as a potential barrier to children receiving the appropriate services to match their treatment needs. Moreover, this omission often results in misclassifications of children based on their risk to society or themselves.

Many Localities Do Not Require Multi-Agency Approval for Services

The *Code of Virginia* sets out provisions that determine who is eligible to receive CSA-funded services. Within these provisions, the *Code* identifies children whose services are sum sufficient (otherwise known as mandated), and children whose services are not sum sufficient (or non-mandated). A key feature of the Comprehensive Services Act, however, is the considerable discretion it provides localities in deciding whether persons who are considered mandated or non-mandated actually need CSA-funded services.

While the legislation places a premium on the provision of preventive services to the at-risk population, State guidelines are limited in how local CSA programs should conduct outreach programs, how the local referral process should work, and how eligibility determinations are to be made. Because these types of decisions can greatly impact the magnitude and nature of the CSA population, it is important to analyze how localities have organized the eligibility and assessment process and whether local management practices reflect the intent of CSA legislation.

Legislative Intent of CSA. Before local management practices are reviewed, it is important to make clear the intent of the CSA legislation. As identified in Chapter I, CSA legislation was designed to address problems of duplication of service, unequal access to treatment, and reliance on more expensive forms of care that often accompanied treatment services for at-risk youth. The intent of the CSA legislation is clear: “to create a collaborative system of service and funding that is child-centered, family-focused and community-based.” In theory, CSA’s multi-agency approach properly instituted would assist localities in containing costs and better managing caseloads.

Moreover, CSA legislation encourages local programs to “design and provide services that are responsive to the unique and diverse strengths and needs” of children. The expectation is that a multi-agency team will conduct a thorough assessment of a child and his or her family’s strengths and needs, and then service plans, detailing treatment to address these specific needs, will be developed. In other words, it is not the intent of the CSA legislation to make the child fit into an existing program; rather, the legislation is designed to make service plans fit the needs of the child. Under this model, local human services staff collectively using their expertise would be necessary for program success.

Use of Multi-Agency Teams. Decisions about whether a child is eligible for services are based largely on subjective observations concerning the severity of existing behavioral or emotional problems. Further, the *Code of Virginia* is silent on what local entity should make this initial assessment and whether this decision should be subject to a higher level of review. This substantially increases the possibility that localities will use a variety of approaches to govern how children are referred to CSA, who makes the initial assessment, and whether these decisions are subject to a higher level of review.

Presently, there are a number of methods by which children can access CSA services. Generally, parental referrals or referrals from local child-serving agency staff are the entry point of the CSA eligibility process. After a referral has been made, the child is screened, usually by local agency staff or by a multi-agency team, to determine if he or she meets CSA eligibility criteria. For children meeting pre-determined eligibility requirements, additional assessments are made in order to determine what services are appropriate.

Based on the legislative intent of CSA, one would expect the great majority of CSA assessments to undergo a multi-agency review at some point prior to funding approval. However, officials on the local level have found opportunities to determine children eligible for CSA funding without multi-agency assessment or approval. Both the courts and local case managers have circumvented the normal CSA screening and eligibility process and accessed CSA funds.

Local program staff have indicated that judges often bypass the normal CSA eligibility determination process by ordering multi-agency teams to provide specific services to juvenile offenders. Specifically, 64 percent of the localities in the subset responding to a JLARC staff survey indicated that juvenile court judges issue court

orders requiring local CSA programs to provide services to juvenile offenders. Multi-agency team members have indicated that these court ordered referrals not only circumvent the CSA collaborative process, but court orders may also include treatment services which may not be appropriate for the juvenile offender given the youth's particular problems.

Local case managers have also frequently accessed CSA funds while bypassing the multi-agency review system. Seventy-five percent of respondents to a JLARC staff survey of case managers indicated that they conduct initial eligibility assessments outside of the multi-agency process. Almost half (48 percent) of these case managers added that their eligibility assessment decisions are not always reviewed by a multi-agency team. These unilateral eligibility decisions would be of little concern if a multi-agency approach were instituted prior to service determinations or funding approval. But, when case managers assess eligibility, determine services, and access CSA funds without multi-agency collaboration, compliance with legislative intent and integrity of CSA dollars spent can be brought into question.

Impact of Local Practices on Children Served by CSA Funds. As mentioned above, the use of CSA funds are to be explored only after the resources of local child-serving agencies have been exhausted and eligibility requirements have been fulfilled. It is the assumption that eligibility screening and assessment practices filter out cases which should not be funded through CSA. As part of this review, JLARC staff examined whether certain local practices impact the risk and number of children receiving services.

As a part of this analysis, JLARC staff first identified the total number of youth served in each locality in relation to the 0 to 17 year old population. Those localities with a figure higher than the sample-wide average were classified as high service relative to the others in JLARC's subset. Through the use of structured interviews and local surveys, information was collected on the local referral and eligibility assessment practices that might influence the risk and number of children coming into CSA.

As Table 12 indicates, localities which manipulated eligibility criteria in order to access CSA services and localities that were court ordered to provide services to youth more frequently fell into the high service proportion category. Conversely, localities with higher rates of multi-agency reviews of case manager eligibility determinations and higher rates of initial assessments at the multi-agency level generally fell into the low service proportion category. This would suggest that unilateral eligibility determinations increase the number of at-risk youth served with CSA funds.

The Risk Profile of CSA Participants. The question of whether local eligibility determination practices contribute to poor targeting under CSA — providing services to children with only marginal risk — can only be addressed through data on the risk profile of CSA participants. To examine this issue, JLARC staff used an assessment tool referred to as the Childhood Severity of Psychiatric Illness (CSPI), which was developed by the director of the Mental Health Services and Policy Program at

Table 12

Local CSA Referral and Eligibility Assessment Practices

| Components of CSA Referral And Assessment | Locality Served High Proportion of Youth Population (n=8) | Locality Served Low Proportion of Youth Population (n=14) |
|--|---|---|
| Court orders issued to mandate children for service | 50% | 29% |
| Initial level at which child is screened for CSA eligibility - Case manager level - FAPT level | 88% 12% | 71% 29% |
| Case manager assessment decisions always reviewed at higher level | *39% | *58% |
| Local program participants make mandated eligibility determinations for child who may not fit the eligibility category in order to provide child with services | 63% | 43% |

Note: *Results are from JLARC survey of case managers; n=41 for localities serving a high proportion of youth population and n=83 for localities serving a low proportion of youth population.

Source: JLARC staff analysis of CSA case manager survey, structured interview data, and locality survey.

Northwestern University. Developed as a decision support tool for case managers and clinical decision makers, the CSPI provides for the structured assessment of children with possible mental health service needs along a set of dimensions found to be relevant to clinical decision making. The instrument is used statewide by caseworkers in Illinois' mental health system to assess the dysfunctions and risks associated with at-risk children. The CSPI incorporates three dimensions along which children's mental health needs and service planning occurs.

The first dimension of the CSPI involves the nature and severity of the child's symptoms of psychopathology. Children with serious emotional disorders may exhibit any of the three basic types of symptoms: neuropsychiatric disturbances (psychiatric disorders with a known neurological base, such as schizophrenia), emotional disturbances (psychiatric disorders, such as depression or social withdrawal), or behavioral disturbances (for example, antisocial behavior or compliance problems with authority). Whether a child is impulsive (fails to pay attention or is easily distracted, such as Attention Deficit and Hyperactivity Disorder or has aggressive behaviors) and the consistency of any observed symptoms (the settings and how often) are also important aspects of the child's "symptomatology."

However, while symptoms may influence treatment decisions (for example, decisions about the use of medication or the need for counseling), the setting in which treatment occurs is generally based on risk management considerations. Therefore, the second dimension is the risks identified for children which include: potential to commit suicide, dangerous (assaultive or aggressive) behavior, criminality/delinquency, runaway behavior, and predatory sexual behavior. The four levels of risk identified by the CSPI are as follows:

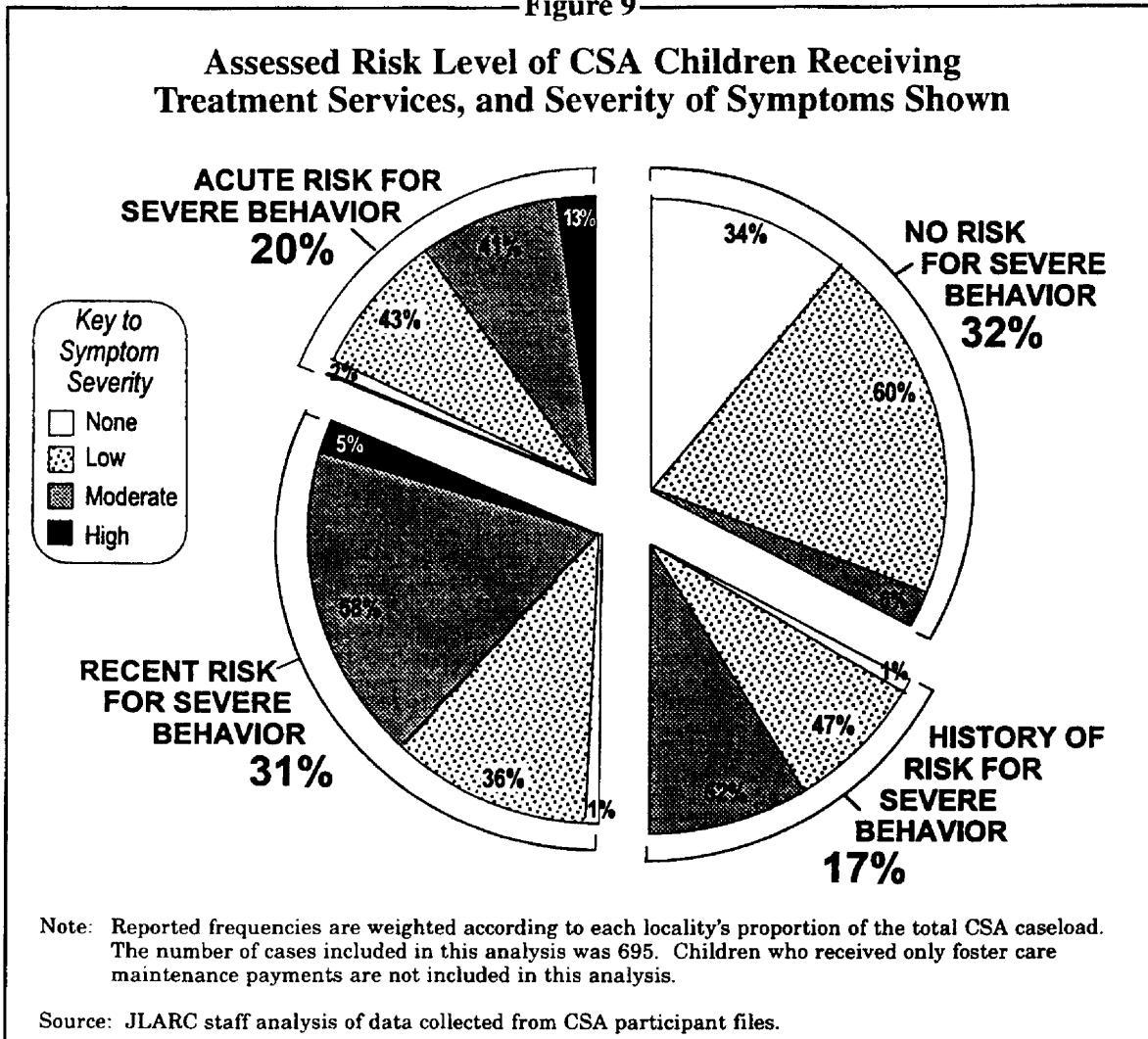
- **No Risk.** The child has displayed no current evidence nor a history of suicidal tendencies, dangerousness, criminality, runaway, or predatory sexual behavior.
- **History of Risk.** The child has a history of suicide attempts, dangerousness, criminality, or runaway behaviors, but appears to present no current risk and no history of predatory behavior.
- **Recent Risk.** The child has engaged in suicidal, dangerous, criminal, or runaway behavior within 30 days of referral, but is not at imminent risk.
- **Acute Risk.** The child is at imminent risk for suicidal, dangerousness, criminality, or runaway behavior, or the child has a history or has recently engaged in predatory sexual behavior.

The third CSPI dimension is the capacity of the caregivers to manage the child in the community. While symptoms and risks define much of a child's mental health treatment needs, the caregiver's ability to manage the behavior and set appropriate limits, the motivation of the caregiver to make the necessary changes to solve present problems, and the caregiver's knowledge of the child's strengths and the rationale for treatment require consideration in order to determine whether a child can remain in the community.

During JLARC staff's comprehensive file reviews on 1,144 children, the CSPI was completed by utilizing information completed at the time that CSA-funded treatment services were first initiated. Documents that were reviewed to assess the risk levels of the children included: social history, psychiatric and psychological evaluations, plans of care or individualized education plans (IEPs), treatment and progress notes, admission and discharge summaries, and information found in the multi-agency team files. Using this information, each child in the sample could then be classified according to his or her level of risk at the time they received CSA services.

Figure 9 displays the percentages of the CSA children receiving treatment services based on the four CSPI risk categories and severity of symptoms. This analysis excludes children who received state and local foster care maintenance payments and no additional mental health treatment services. The number and severity of emotional and behavioral symptoms is based on five scales: the presence of neuropsychiatric disturbance, emotional disturbance, antisocial behavior, oppositional behavior and impulsive behavior. Each scale has a rating of 0 (no evidence of a problem) to 3 (severe

Figure 9



evidence of the problem). Any child with a total score of 1 to 5 would be considered to have a low "symptom severity" rating, a score of 6 to 10 would be considered moderate, and a score of 11 to 15 would be considered a high level of symptom severity.

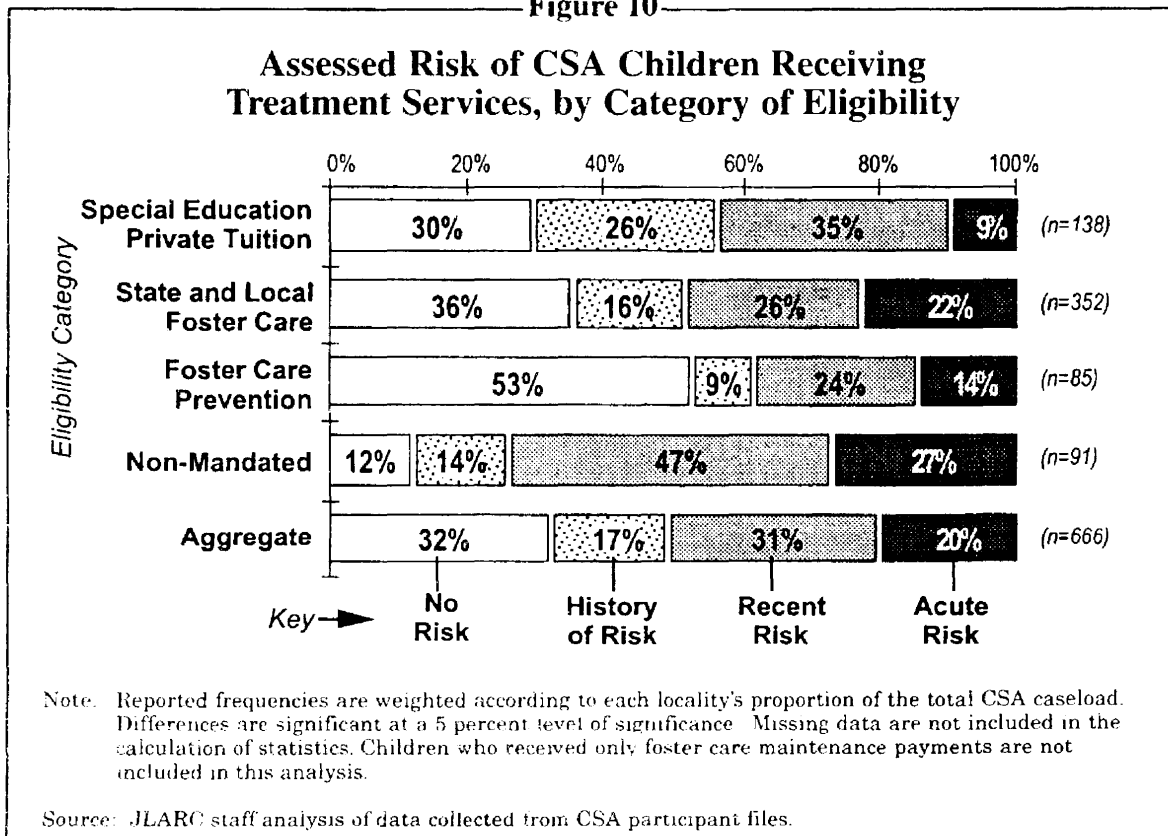
In spite of the CSA program eligibility criteria which requires that a child have multiple behavior or emotional problems, evidence of multiple agency interventions, or be at imminent risk of entering residential care, 32 percent of the children were found to be at no risk when they entered CSA, which means no current or history of risk behaviors. Of those children that were found to exhibit no risk behaviors, 34 percent also had no emotional or behavior symptoms. For the remaining CSA children, 17 percent had a history of risk, but did not exhibit any risk behaviors at time of program entry; 31 percent were found to be a recent risk, which means the child had engaged in risk behaviors in the previous 30 days, but was not presently an acute risk; and 20 percent were found to be at acute risk, which usually requires inpatient psychiatric hospitalization. As illustrated in Figure 9, as the level of risk of the child increases, so does the number and severity of emotional and behavior symptoms.

In some cases, children with no risk enter CSA not because of their problems, but those of their parents. In these cases, while eligibility is established for the child, the mental health treatment services are directed towards the parents. This strategy reflects the prevention goals of CSA. Still, the fact that half of the children entering CSA either had no risk or only a history of risk for serious behavior indicates that the program may have drifted from its intended focus.

Figure 10 illustrates the assessed risk of CSA children based on their eligibility category. As shown, the mandated children (special education, foster care, and foster care prevention) tend to have lower risk levels than the non-mandated children. Most notably, 53 percent of the CSA children that receive CSA services under Foster Care Prevention are experiencing no risk at the initiation of treatment services. While prevention is a legislatively stated goal for CSA, the statute makes clear that CSA funds should be primarily targeted on children with considerable risk.

Types of Cases Not Reviewed by Multi-Agency Teams. It is clearly the intent of the CSA legislation to bring an interagency approach to local program implementation. The *Code of Virginia* establishes and calls for the use of multi-agency teams, but does not require that CSA eligibility or service determinations must be universally conducted by multi-agency teams. Local CPMTs may establish policies under which youths are not required to be reviewed by a multi-agency team and still receive fund-

Figure 10



ing for services. As a result, all local governments have not embraced this concept as a part of the eligibility determination and service assessment process.

Table 13 illustrates how localities in the JLARC subset process CSA cases with respect to the use of multi-agency assessment teams. In the subset, family foster care cases were the least likely to undergo a multi-agency review prior to receiving CSA funds. In 82 percent of the localities, family foster care eligibility and service determinations were unilateral decisions made by local social services staff. Additionally, almost one third (32 percent) of the localities did not require multi-agency reviews for special education private tuition services. Only three localities embraced the multi-agency approach for all services requesting CSA funding.

Table 13

Local Service Assessment Practices in JLARC Subset

| Cases Not Reviewed by Multi-Agency Team Before Receiving CSA Funded Service | Total Localities | Percent of Total Localities |
|---|------------------|-----------------------------|
| None (all cases reviewed) | 3 | 14% |
| Mandated family foster care | 18 | 82% |
| Mandated specialized foster care | 6 | 27% |
| Mandated foster care plus treatment | 6 | 27% |
| Mandated foster care prevention | 6 | 27% |
| Mandated special education | 7 | 32% |
| Non-mandated | 0 | 0% |

Source . JLARC staff analysis of data collected from CSA local interviews.

While all localities required that non-mandated cases undergo multi-agency review prior to funding approval, the multi-agency process was used less frequently for mandated cases. Removing mandated cases from the multi-agency assessment process has its implications. For example, local program officials often debate whether the term mandated refers to the child or to the service that the child receives. When the policy of mandating the child is adopted, the interpretation is that any service that is determined to be appropriate for the child is then mandated and must be provided. On the other hand, when the mandate refers to the service, flexibility exists as to which services that the child receives will be sum sufficient and which services may be deferred or funded through other resources.

Unilateral eligibility determinations coupled with ambiguous interpretations of how the mandated distinction is to be used can have a significant impact on local caseloads and costs. A revealing example of this can be found in the schools' eligibility and service determination process. Although the *Code of Virginia* makes it clear that the only sum sufficient services with a direct connection to local school programs are

special education private tuition services, some localities have stretched the interpretation of the mandated distinction in order to incorporate more special education non-private tuition services, such as classroom aides, into the sum sufficient category.

Many CSA program staff representing local schools suggest that once a child is in a special education program, all of the services that the child requires are mandated and, if requested, should be paid through CSA sum sufficient funding. When these services are part of a child's individualized education program (IEP), some local program staff have decided that these services must be paid for through CSA sum sufficient funding. Because 77 percent of the localities in the subset do not permit CSA multi-agency teams to take part in the development of the IEP, and because these plans take precedence over multi-agency service plans, it can be argued that even in the localities where CSA school funding requests are reviewed by multi-agency teams, these reviews are perfunctory. Therefore, these service determinations are being made outside of the multi-agency process by school personnel.

Amount of Dollars Spent Outside of the Multi-Agency Process. When CSA was established, a widely held assumption was that a group of case managers from several human service agencies could make more informed decisions about the needs of a CSA recipient than one caseworker because the child was supposed to be in need of multiple agency intervention. Moreover, as a group, these same individuals could explore alternatives to the traditional and more expensive treatment approach of residential care. Table 14 indicates that the informed decisionmaking that was envisioned through the multi-agency process occurs in less than half of the cases which are funded through CSA.

In the JLARC subset of localities, 61 percent of the cases receiving CSA-funded services during FY 1995 were not reviewed by a multi-agency team. These cases accounted for 46 percent of the total dollars spent on CSA services. Because a significant number of cases are being processed outside of the multi-agency framework, the ultimate goal of CSA — less expensive community-based treatment — may be frustrated. Moreover, these cases represent a significant proportion of total CSA expenditures.

A closer look at what categories of CSA recipients are determined eligible and receive services without the benefit of a multi-agency approach is more revealing. Figure 11 illustrates categories of CSA recipients as they relate to multi-agency reviews and total dollars spent. For eligibility categories not reviewed by multi-agency teams, family foster care services accounted for 42 percent of the total cases but only nine percent of the total dollars spent. Family foster care services — which typically include a minimal maintenance payment — are not treatment oriented and the costs are generally fixed and lower than costs for treatment services. Moreover, the majority of localities in the sample indicated that this was a service that need not go through the multi-agency approach in order to access CSA funds. Therefore the high proportion of family foster care cases not reviewed by multi-agency teams does not come as a surprise, nor is it necessarily inappropriate given that these cases involved no treatment.

Table 14

**Multi-Agency Service Determinations
and Local CSA Practices FY 1995**

| Was Multi-Agency Review Conducted? | Total Cases | Proportion of Total Cases | Total Dollars | Proportion of Total Dollars |
|---------------------------------------|-------------|------------------------------|---------------|--------------------------------|
| Yes | 374 | 39% | \$ 7,403,226 | 54% |
| No | 573 | 61% | \$ 6,349,394 | 46% |

Note. The reported frequencies are weighted based according to the localities proportion of the total CSA caseload. Data from the City of Richmond are not included in analysis due to insufficient cost data, and cases with missing cost data are also excluded from this analysis. Analysis based on 1,078 unweighted cases.

Source: JLARC staff analysis of data collected from CSA participant files.

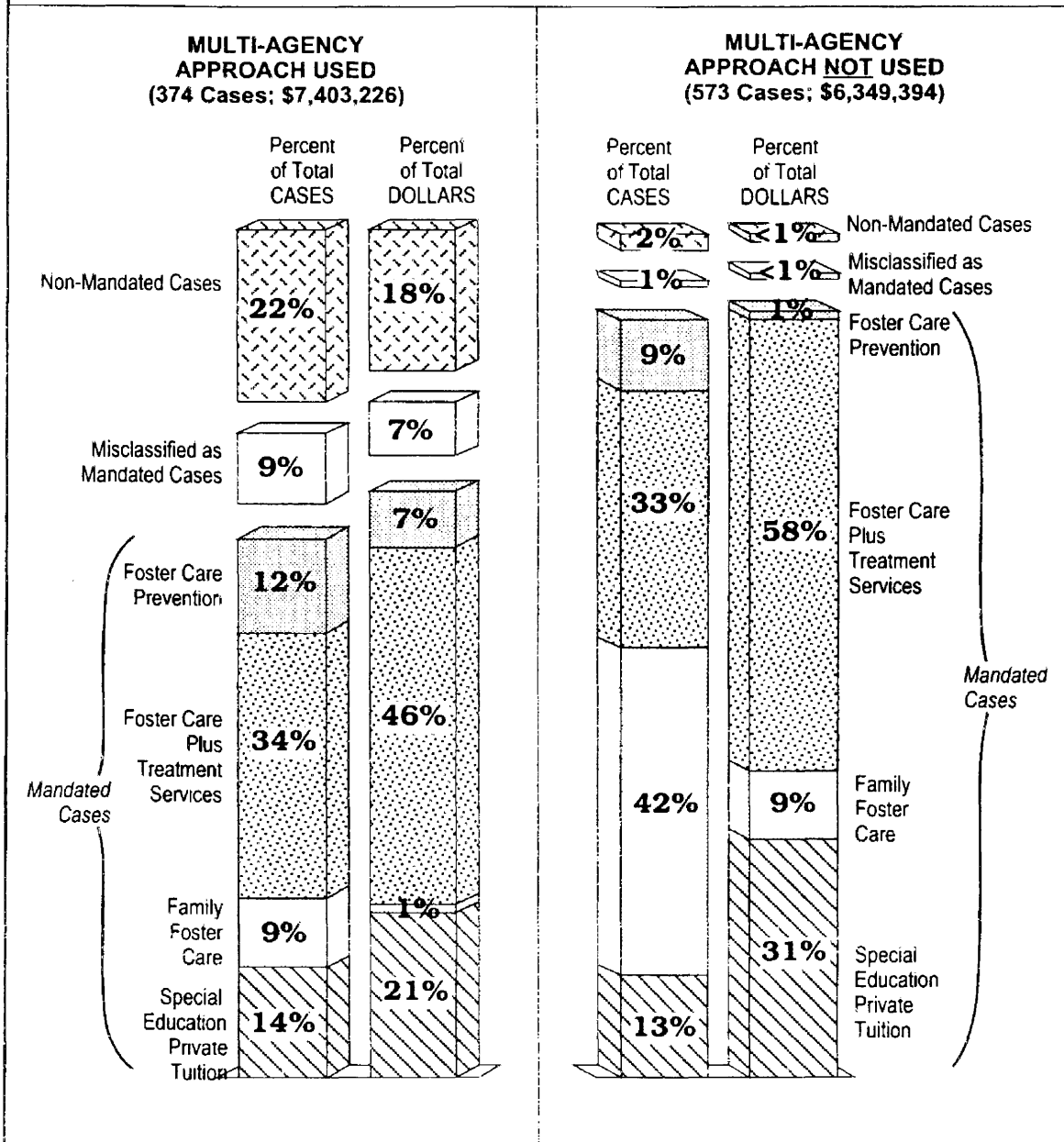
However, what is of some concern is the proportion of cases from certain eligibility categories involving treatment and the total dollars which they represent. Overall, 49 percent of all cases involving treatment were handled outside of the multi-agency process. For instance, special education private tuition services accounted for 13 percent of the total cases not reviewed by multi-agency teams but 31 percent of the total dollars spent outside of the multi-agency assessment process. Foster care plus treatment services accounted for 33 percent of the total cases but 58 percent of the total dollars. Combined, the two categories accounted for 46 percent of the total cases and 89 percent of the total dollars spent outside of the multi-agency process. The final three eligibility categories, foster care prevention, all non-mandated services, and some misclassified cases, combined for only 12 percent of the total cases and less than two percent of the total costs.

Removing Foster Care from the CSA Pool of Funds. As CSA was created to serve high risk youth who are beyond the scope of a single agency's resources, it is unclear why the funding for foster care maintenance payments and related social services are included in the CSA pool of funds. Since "straight foster care" children (meaning children who only receive foster care payments from CSA) do not display the risk which requires other treatment services, the funding for these cases should be managed by local welfare agencies. Likewise, payments for regular social services which do not involve treatment should also be managed by local welfare agencies. Under such an arrangement, only those children who demonstrate behavioral problems would be required to appear before a multi-agency team to access treatment services.

Under the current system, local staff often use the fact that a child is in foster care as the justification for making unilateral decisions about any treatment needs. By allowing the local welfare agencies to control the funding for the foster care program, but keeping funding for treatment services within CSA, local welfare agencies will be required to appear before the multi-agency team to access any funds needed to pay for treatment services.

Figure 11

Percentages of Participants and Dollars Spent in CSA Programs, According to Whether Multi-Agency Approach Was Utilized



Notes: The reported frequencies are weighted based on the localities' proportion of the total CSA caseload. Missing data is not included in the calculation of statistics: data from the City of Richmond is not included due to insufficient cost data.

Source: JLARC staff analysis of data collected from CSA participant files.

Because the dollars for the foster care program are included in the current CSA pool of funds, JLARC staff conducted an analysis of a sample of 1,144 children who received CSA funding in FY 1995. The purpose of this analysis was to determine what proportion of the dollars spent on these children was for foster care maintenance and related social services (for example daycare and independent living grants for children in foster care).

This analysis revealed that approximately eight percent of the funding was used for family foster care services. Approximately one percent was used for other types of foster care maintenance payments, related services, and social services such as day care and independent living grants. Based on this analysis, JLARC staff concluded that approximately ten percent of the total CSA pool of funds are used to finance family foster care and social services. The CSA budget for FY 1997 was approximately \$150 million. Using this budget figure and the percentage generated from the JLARC sample, it is estimated that approximately \$15 million was spent on family foster care, related services, and social services. This figure does not include all funds spent on family foster care and maintenance services because some of these services are funded outside of the CSA pool — usually through Title IV-E funds.

Early findings on the proportion of low-risk children in CSA suggest that a policy change to reduce the number of these children entering the program could drive down the total cost of CSA in the short-term. However, such an approach runs counter to the prevention language currently in the CSA statute and may have long-term cost implications as well. Rather than tightening the eligibility criteria and risk denying early intervention services to children from troubled homes, CSA would be better served if localities ensured that cases in which families need only social services to prevent the removal of the child from the home are managed by welfare staff, completely apart from the CSA program. Accordingly, approximately ten percent of the CSA budget should be transferred to DSS for its administration of the family foster care program and basic social services.

For other CSA cases, specifically special education private tuition and children in family foster care who receive other treatment services, the omission from the CSA collaborative process, and the reliance on individual case managers or single agencies to make service determinations for children with varying degrees of risk, appears to run counter to the legislative intent of CSA. The magnitude of dollars spent on certain eligibility categories outside of the multi-agency approach indicates that closer scrutiny of these cases may be necessary to ensure the CSA funds are appropriately spent.

Recommendation (2). The General Assembly may wish to amend the *Code of Virginia* to remove the funding for the family foster care program and basic social services out of the CSA budget and transfer it back into the Department of Social Services. Approximately ten percent of the FY 1997 CSA budget, or \$15 million, should be transferred from the CSA State pool of funds to the Department of Social Services for FY 1999. The CSA funding formula for this and subsequent years should reflect this change.

Recommendation (3). The General Assembly may wish to amend Section 2.1-755 of the *Code of Virginia* to require that all cases for which treatment services (not foster care maintenance) are requested be reviewed by a local multi-agency team prior to the development of the service plan. Cases for which service plans are developed outside of this process should not be eligible for CSA funding.

Local Policies, Inadequate Resources, and Lack of Uniformity in the Assessment Process Fosters Inappropriate Placements

Despite the potential consequences to the child which can flow from poor placement decisions, localities are faced with a variety of factors that may impact the case manager and the multi-agency team's ability to approve treatment services that match the child's identified needs. Some of these factors, such as local policies and availability of community resources, are beyond their control. Other factors, such as the failure to use a uniform screening and assessment instrument to guide the service decisionmaking process, are within their control.

Lack of Uniform Assessment Instrument. One factor that drives inappropriate placements is the lack of a uniform screening and assessment process in Virginia which can be used to direct troubled youth to an appropriate placement. The potential problems created by this are clear. With no uniformity in determining what services a child may need, children may be placed in the community prematurely, or children may receive more services than needed. In addition, with no common way to assess a child's needs, there is no way to ensure that there is equitable access to publicly funded care for "at risk" children within a locality or across the Commonwealth.

In one locality, the factors in a child's family or background that are used to support the deflection of the child from a residential placement may be very different from those in another locality. This could foster inconsistencies in the assessment and placement process, and result in the inappropriate use of residential treatment. Conversely, some localities may misclassify high risk children and place them in community-based settings because they have not systematically identified the factors which support residential treatment or psychiatric hospitalization.

During the file reviews and interviews with local case managers, JLARC staff found that case managers assess a child's needs differently, both within an agency and across agencies. Most "assessments" were general guidelines in which case managers recorded a child's strengths, weaknesses, and available family support. While this information is useful to the child's assigned case manager, it is not easily communicated to others involved with the child's treatment plan. The lack of a common assessment instrument, with a standard way of identifying the child's level of impairment and ability to function within the community, causes the child to undergo multiple assessments by each agency that serves him. This process creates a "band-aid" approach to service delivery.

Instead, what is needed is a comprehensive approach that identifies all the child's needs the first time he or she comes into contact with the initial agency. The use of a common assessment to determine the need for all CSA funded services is also critical for localities to justify the services provided to the child. This is particularly important when a multi-agency team is faced with making funding priority decisions on a diverse group of children.

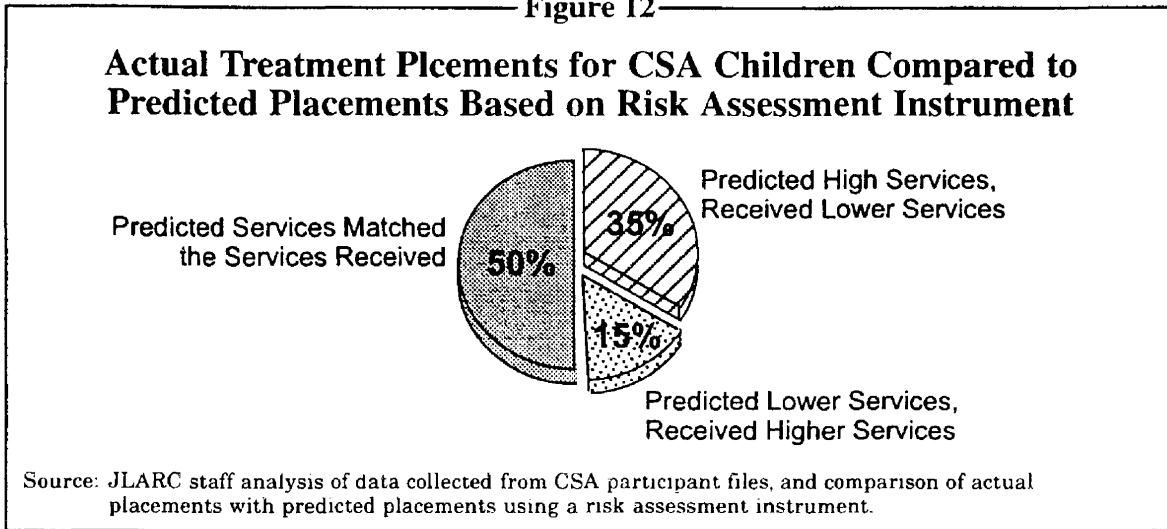
Matching Services to Identified Treatment Needs and Risk. A key question concerning the success of the CSA program is to determine whether the children received the appropriate level of services based on their assessed needs. One benefit of using the CSPI is that the instrument not only provides an assessment of the risk of the child but also indicates the setting in which the child should possibly be treated. The mental health expert who developed the CSPI stated that while symptoms of the child, such as emotional and behavioral problems, should influence treatment decisions, these factors alone are not sufficient to determine the setting in which treatment should occur. Rather, these decisions should be based on the risks that children pose to themselves and the community, as well as the capacity of their guardians or caregivers to manage their behavior.

For example, the guidelines might recommend a hospital placement for a child who has mild impulse control problems, mild dysfunction, no symptoms of substance abuse, but a recent history of suicide risk. A child with similar characteristics but no history of suicide risk may be given a lower service placement. Because JLARC staff collected data on the problems that children in CSA were experiencing at the time that they were first placed in a CSA-funded treatment program, it was possible to compare the services that were received with those recommended by the CSPI guidelines.

Findings from this review indicate that only half (50 percent) of the children receiving CSA treatment services received services that matched the CSPI predicted service (Figure 12). Of the children who did not receive services that matched their identified needs, 35 percent were assessed to need higher services than they actually received. The remaining 15 percent received services in a treatment setting that was more restrictive than recommended by the CSPI. A variety of factors may explain this finding, such as lack of community resources or the ability to adequately serve the child in a less restrictive environment. Nonetheless, from a cost effective perspective, the 15 percent of the children who were predicted to need less restrictive services, but actually received more restrictive services, should receive close scrutiny.

To understand the nature of service need mismatches and to isolate possible factors that would explain these differences, JLARC staff examined the placement decisions based on the assessed risk of the child, the impact of the multi-team approach on the placement decisions, and the nature of mismatches by specific services. As shown in Table 15, 42 percent of the children who were assessed at the level of acute risk and predicted for high services such as inpatient psychiatric care or residential psychiatric treatment centers, received lower services than their assessment indicated.

Figure 12



At the same time, 27 percent of the children with no recent risk behaviors and 29 percent with only a history of risk received services higher than their assessment indicated. Next, JLARC staff explored whether service mismatches were more likely to

Table 15

A Comparison of CSA Placement or Service Decisions Based on the Assessed Risk of the Child

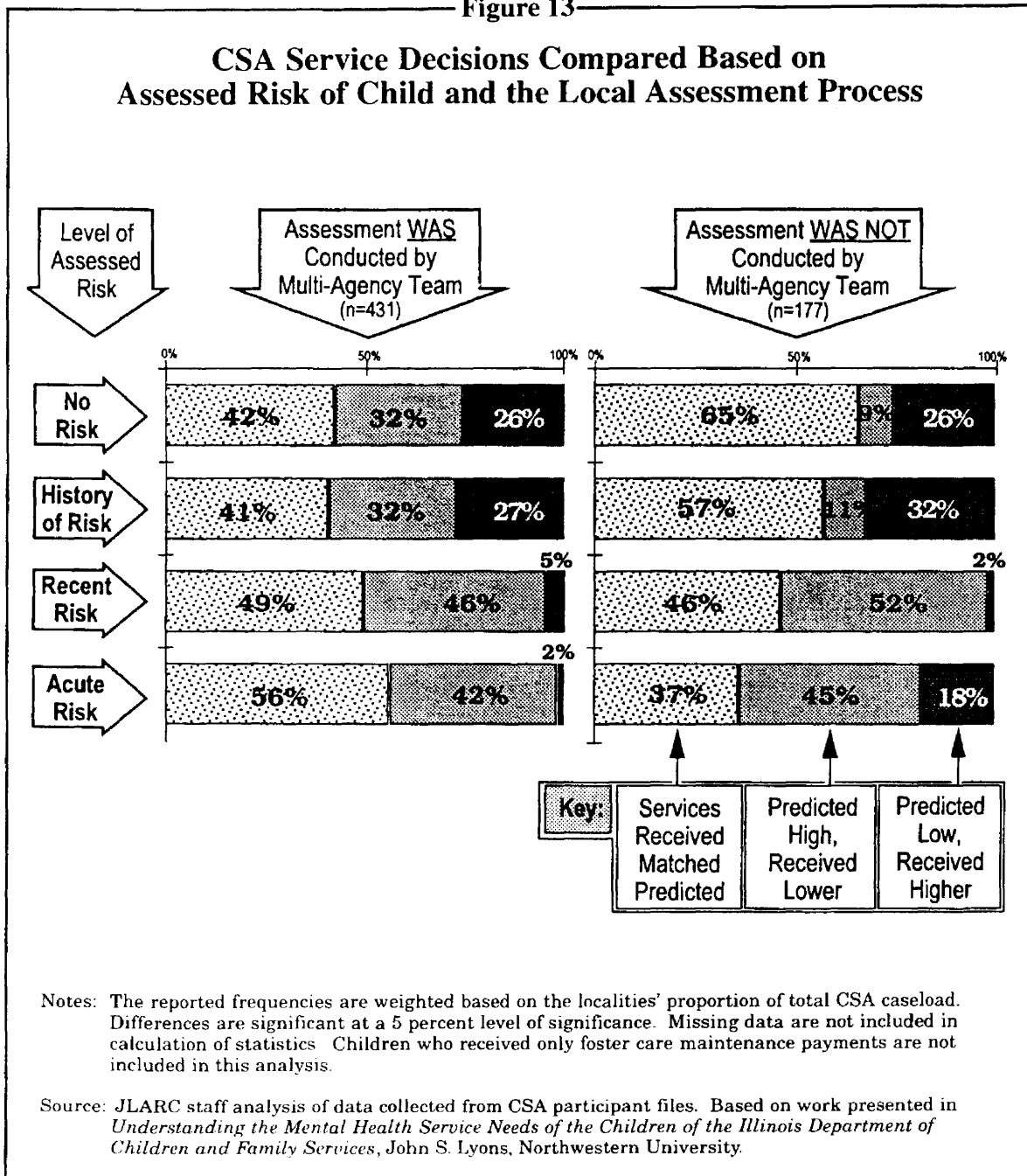
| Assessed Risk | Did the CSA Placement or Service Decision Match the Prediction of the Risk Assessment?* | | |
|-----------------|---|--|--|
| | Yes | No | |
| | | Assessment predicted the need for high services and the child received lower services. | Assessment predicted the need for low services and the child received higher services. |
| No Risk | 55% | 18% | 27% |
| History of Risk | 48% | 23% | 29% |
| Recent Risk | 49% | 47% | 4% |
| Acute Risk | 50% | 42% | 8% |

Notes: The reported frequencies are weighted based on the localities proportion of total CSA caseload. The Chi-square statistic indicated that differences are significant at a 5 percent level of significance. Missing data are not included in calculation of statistics.

Source: JLARC staff analysis of data collected from CSA participant files. Based on work presented in "Understanding The Mental Health Service Needs Of The Children of The Illinois Department of Children And Family Services", John S. Lyons. Northwestern University.

occur when the localities failed to rely on the multi-agency team approach to assess service needs and make placement decisions. As shown in Figure 13 below, the use of a multi-agency team does improve the likelihood that a child with recent or acute risks received the services needed. However, the proportion of service mismatches remains high.

Figure 13



Rather than assume the multi-agency team process is at fault, it is more likely that local policies and the lack of uniform assessment and level of care criteria caused the children to be placed in services that did not match their needs. Multi-agency teams, as well as the individual case managers, that make placement decisions may be basing their decisions on a variety of factors that do not relate to the child's assessed risk. As indicated earlier, placement decisions based on one factor alone, such as the symptoms of the child, rather than a combination of emotional and behavioral symptoms, risk factors, and caregiver management capabilities, could be an important factor in service mismatches. In addition, the resources available to the locality to provide community-based services will impact the service mismatch.

Table 16 pinpoints the type of placement that was inappropriately made. Most children (69 percent) who receive CSA funded psychiatric hospital or residential care were also predicted to need this level of care, 27 percent were predicted to only need specialized foster care or private day schools, and four percent were predicted to only need community based services. Half of the children (51 percent) who received CSA funded specialized foster care or private day schools were predicted to need this level of care, 40 percent were predicted to need a higher placement, such as a hospital or residential setting, and nine percent were predicted to need lower services in the community. Only 22 percent of the children who received only community based care services

Table 16

A Comparison of Actual CSA Service Decisions to Risk Assessment Predictions

| Actual CSA Service Decision | Services Predicted by the Risk Assessment | | | Total |
|---|---|---|--------------------|-------|
| | Hospital/Residential Care | Specialized Foster Care/Private Day Schools | Community Services | |
| Hospital/Residential Care | 69% | 27% | 4% | 100% |
| Specialized Foster Care/Private Day Schools | 40% | 51% | 9% | 100% |
| Community Services | 44% | 34% | 22% | 100% |

Notes: The reported frequencies are weighted based on the localities proportion of total CSA caseload. Differences are significant at a 5 percent level of significance. Missing data are not included in calculation of statistics. Children who received only foster care maintenance payments are not included in this analysis.

Source: JLARC staff analysis of data collected from CSA participant files. Based on work presented in *Understanding the Mental Health Service Needs of the Children of The Illinois Department of Children and Family Services*, John S. Lyons, Northwestern University.

were predicted to need these services. Most (78 percent) of the children who only received community services were predicted to need higher services such as hospital, residential care or specialized foster care.

Figure 14 compares the actual placements and predicted service needs by the risk of the child. As shown in the figure, it appears that the lower the risk of the child, the more likely it was for the child to receive services that were higher than indicated on their assessment. Accordingly, as the risk of the child increased, the child was more likely to receive services that were lower than indicated by their assessment. For example, for children who were assessed at no risk and predicted that they could be served in the community, 15 percent actually received hospital or residential care. Conversely, for children who were assessed recent or acute risk and predicted to need residential or hospital care, almost half of these children were served through therapeutic foster care or other community services.

Impact of Local Policies and Other External Factors. It is important to note that some of the mismatches that were observed were due to factors that are beyond the control of the case manager or multi-agency team. For example, on client assessment, some localities have policies in place that instruct case managers to try all least restrictive community services prior to the approval of residential care. While this supports the goal of CSA to serve the child in the least restrictive environment, in some cases this may be an inappropriate approach for a child who must “fail” to benefit from other services in order to receive the level of care he or she truly needs. Other localities find that the Individualized Education Plan (IEP) for children served through the schools or the court hearings for juvenile court youth drive the child’s service options.

In still other localities, case managers make placement decisions based upon that fact that there are inadequate resources, both for funding and for community alternatives. One locality indicated that it had difficulty procuring appropriate services for non-English speaking children. In another locality, a case manager indicated that the lack of funds for non-mandated children was the reason a child received services that really did not meet the child’s needs. In a rural locality, the child’s need for residential placement consumed a quarter of the locality’s budget, so the multi-agency team required that less expensive alternative community services be tried.

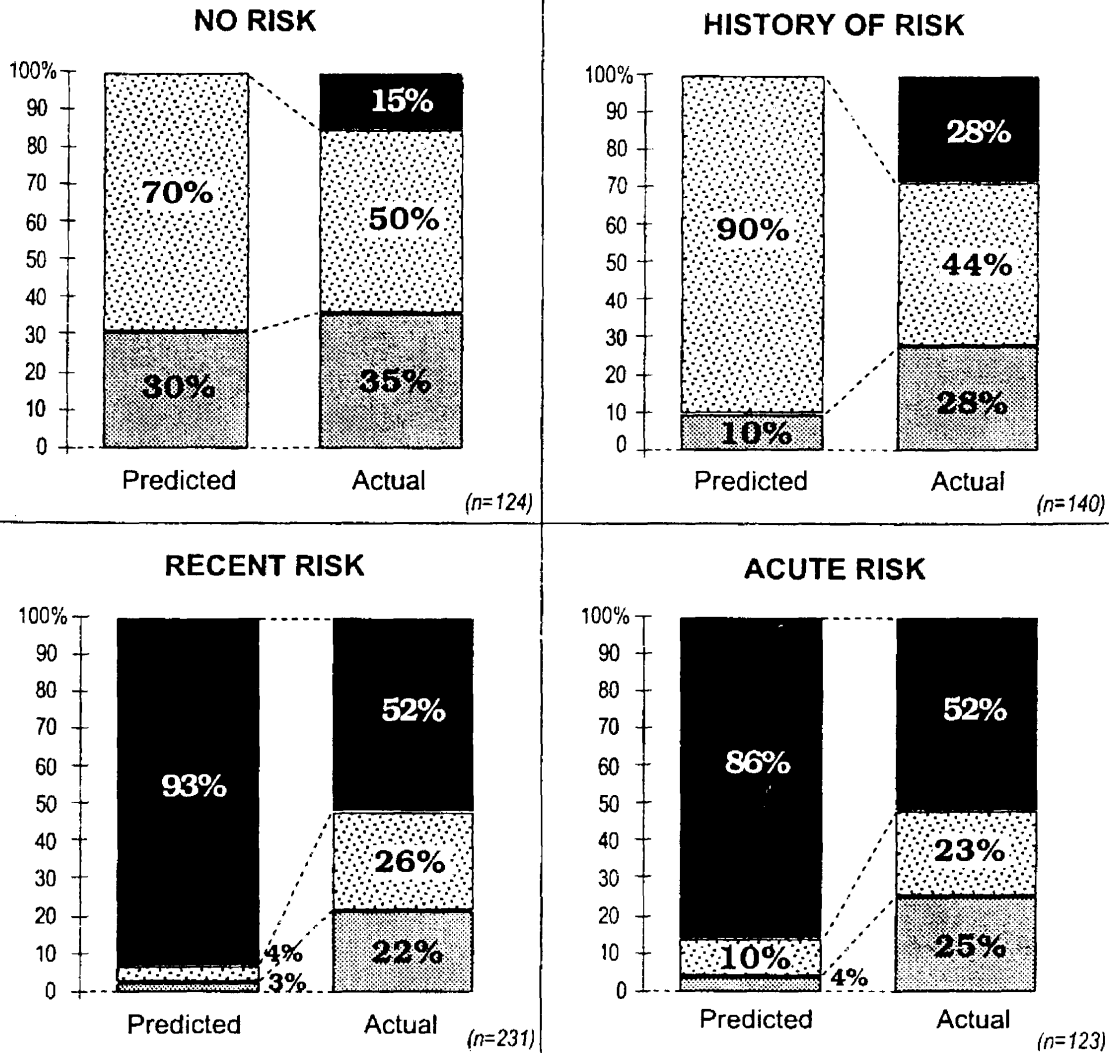
During JLARC site visits, staff found that a number of localities placed children in specialized or therapeutic foster care who did not have an identified need for this higher and more expensive level of care. The following case example highlights this misuse of specialized foster care:

The child came to CSA in family foster care as a result of neglect by the mother who was a drug addict. The child did not have any significant behavioral or emotional problems. However, after a year of family foster care, the child was upgraded into specialized foster care through a private agency because the locality determined, after the child experienced a minor behavioral problem, that the child was in

Figure 14

Actual CSA Service Decisions Compared to Risk Assessment Service Predictions, by Category of Assessed Risk

Key to Services
 Community Services (stippled pattern)
 Specialized Foster Care / Day School (dotted pattern)
 Hospital / Residential Care (solid black)



Notes: The reported frequencies are weighted based on the locality's proportion of total CSA caseload. Differences are significant at a 5 percent level of significance. Missing data are not included in the calculation of statistics. Total cases = 618

Source: JLARC staff analysis of data collected from CSA participant files.

need of a two-parent foster home. There were no two parent foster homes available through the local department of social services, so the locality had to use a private agency for a specialized foster placement (the only thing that made it "specialized" in this case was the need for

a two-parent home). The child was in specialized foster care for approximately one year at a cost of \$21,324. This is compared to the previous year's cost in family foster care of \$4,047.

This case example is indicative of the problem found in some localities concerning the availability of family foster homes and their forced reliance on the use of specialized foster home placement for children who do not necessarily need or even receive the added services specialized foster care is supposed to provide. Other localities indicated that they have to reimburse foster care parents at the specialized foster care rate in order to have enough foster parents to serve the children. Another locality paid specialized foster care rates for two siblings when only one child met the need for specialized foster care in order to keep the children together. Many of these particular service mismatches are made outside of the multi-agency team process. It is important to note that the children in specialized foster care that do not require this level of service do not receive any additional services for the extra money that is spent. Examples such as these help explain why 15 percent of the children who were assessed to need lower services actually received higher services than needed.

There are also a variety of reasons that children who have the predicted need for higher services receive lower services. In some localities the children who are potentially "under served" are the non-mandated population. While the predicted level of care for these children may indicate the need for hospital or residential care, the family receives home based services instead. During interviews, local case managers indicated that they must offer the child outpatient counseling or in-home services, and these services must "fail" prior to being able to place the child in a residential setting. Juvenile court staff also indicated that if they do not get CSA funds for a non-mandated child in the first two months of the fiscal year, there is no more money left, and they must use their own agency funds to serve a child. Again, this child is usually provided with fewer services than needed.

In some localities, the mandated children who receive services under special education private tuition are the ones that are potentially "under served." Their predicted level of service, based on the assessed risk of the child, indicates the need for hospital or residential care, but the child receives services through a private day school. These alternative lower level of care settings may be examples of localities that have successfully expanded the use of comprehensive, well-coordinated community based care services, or they may be indicative of localities trying to exhaust all community based alternatives prior to selecting the higher cost of inpatient psychiatric or residential placement. Local case managers indicated that sometimes a child is able to remain in the community and receive lower services than predicted because the child's family is intact and strongly motivated to keep the child at home.

Nonetheless, in order to minimize inappropriate placements for children and to facilitate the ability of the agencies to work together on a comprehensive treatment plan, local staff should use a more standardized assessment tool to guide the service decisionmaking process. Work is currently under way through the State Executive Council to provide localities with the option of using a standardized assessment tool,

known as the Child and Adolescent Functional Assessment Scale (CAFAS). The purpose of CAFAS is to assess the child's level of impairment and the effect that problem behaviors and symptoms have on the child's daily functioning. This multidimensional tool is user friendly and contains elements, such as emotional and behavioral symptoms, caregiver capacity, and levels of risk, that are similar to the assessment instrument used in the JLARC study. In addition, it also has the capacity to categorize level of impairments and identify appropriate levels of care. The findings from this review support the direction that the State is taking in the use of one common assessment. However, because JLARC staff found that almost half of the children served through CSA are receiving services that do not match their assessed risk, a mandatory, state-wide use of one common assessment is recommended.

Recommendation (4). The General Assembly may wish to require that the State Executive Council adopt a mandatory uniform assessment process, to be used by all localities, which identifies the appropriate level of care for various levels of risk, and ensures that CSA participants will receive services they need and be served in the least restrictive environment. Training needs for local staff to use the uniform assessment process will need to be addressed.

CSA UTILIZATION MANAGEMENT

With the rising costs of caring for CSA children, there is considerable pressure to enhance accountability and control costs. The goal of this accountability is to ensure that the children are receiving quality services in the least restrictive and appropriate setting and to ensure that payments are consistent with efficiency, economy, and quality of care. The CSA study mandate requests that JLARC review "a process through which each placement is reviewed every six months to see if appropriate progress is being made and if other alternatives may be more appropriate." The *Code of Virginia* requires each locality to designate a person who is responsible for monitoring the individual care plan developed for each child and family served under CSA and to establish quality assurance and accountability procedures for program utilization and funds management. In general terms, these two requirements describe the two components of utilization management: case management and utilization review. While the focus of case management is on the individual child's identified needs and the services they receive, the purpose of utilization review is to evaluate how well the program is meeting its goals.

After evaluating how local policies impacted who receives CSA services and what services they receive, JLARC staff examined local CSA utilization management activities. While it is evident that each locality has a structure in place which could be used to conduct comprehensive utilization management activities, JLARC staff found that the actual process for these activities in the localities lacked the basic elements of sound utilization management. Local guidelines for both case management and utilization review were often used interchangeably or inconsistently and were vague. While there may be written guidelines for case managers to use to monitor specific cases, many of the guidelines were general and provided no set schedule for this review.

Based upon JLARC staff's review of provider documentation, improved case management and utilization review of all providers — not just residential providers — is warranted. Without proper utilization management, children may receive services longer than necessary at much higher cost. In other cases, the services may simply be inappropriate based on the needs of the child.

Local CSA Utilization Management Policies Are Not Comprehensive

Two traditional utilization management strategies are case management and utilization review. Case management is a system under which responsibility for locating, coordinating, and monitoring services rests with a designated person or organization. Case management includes all of the following components: defining and identifying the target population, performance of a preliminary screening and eligibility for services, performance of a comprehensive assessment of the child's needs, development of a plan of care, implementation of the plan of care, monitoring of the services delivered, and periodically completing a formal review of the child's status.

Utilization review is a set of procedures for determining how well a program is meeting its stated goals. This review safeguards against the unnecessary utilization of care and services. There are a variety of methods for conducting utilization review, including: focusing on the structure, such as staff qualifications and client file documentation; focusing on the process, such as ensuring the children meet criteria and monitoring the cost effectiveness of the care plan; and/or focusing on outcomes, such as family satisfaction with services and ensuring that the goals in the plan of care are appropriate and achieved. National standards recommend that this systematic evaluation of the program should be conducted annually (at a minimum) by someone other than the case managers.

CSA Case Management Activities. For children served by CSA, the *Code of Virginia* requires multi-agency assessment teams to develop individual family services plans in accordance with local program policies. The *Code* also requires that these plans, which detail the services that the child will receive, be appropriate and cost-effective. Moreover, the multi-agency assessment team is required to designate a person who is responsible for monitoring and reporting progress which is made toward fulfilling the individual family services plans. Although these requirements are established in the *Code*, local program officials have the authority to prescribe how CSA case management activities will occur. Variations in activities among localities could impact the frequency and consistency of case management and the effectiveness of CSA expenditures.

As mentioned previously, local CSA programs have CSA structures in place that are required by the *Code of Virginia*. In the area of case management, localities have instituted policies governing the referral and assessment process. However, respondents to a JLARC case manager survey indicated that local CSA case monitoring requirements are not always clear and monitoring activities are not always consistent.

Although 65 percent of the case managers indicated that their local CSA leadership had established written guidelines regarding case monitoring activities, 28 percent of the respondents indicated that they have no written guidelines which direct them to monitor CSA cases in a specific manner. Consequently, selected case monitoring activities lacked consistency. Table 17 shows the frequency of contact by type as reported by case managers.

Table 17

Monitoring Activities of Local Case Managers

| Frequency of Contact | Selected Case Manager Monitoring Activities | | |
|----------------------|---|------------------------|-----------------------------|
| | Telephone Contact (n=165) | Site Visits (n=162) | Progress Reports (n=165) |
| At least weekly | 27% | 8% | 0% |
| Monthly | 38% | 25% | 46% |
| Quarterly | 8% | 33% | 32% |
| Semi-annually | 0% | 2% | 1% |
| Annually | 1% | 2% | 2% |
| Never | 2% | 7% | 6% |
| No set schedule | 24% | 23% | 13% |
| Total | 100% | 100% | 100% |

Source: JLARC staff analysis of data from CSA Case Manager Surveys.

When queried on three types of case monitoring activities, telephone contacts, site visits, and written progress report requests, respondents often indicated that they followed no set schedule. Twenty-four percent of respondents indicated that they follow no set schedule for telephone contacts, 23 percent followed no set schedule for site visits, and 19 percent either never requested written progress reports or followed no set schedule for progress report requests.

The lack of uniformity and consistency in case monitoring activities can result in poor services for children in care and inappropriate use of CSA funds. For example:

CSA case monitoring activities are not always clear to local program staff. During a JLARC staff interview with a local family planning and assessment team, a team member indicated that once funding for services is approved by the local community policy and management team and the child receives treatment services outside of the locality, she closes the case and provides no monitoring activities. The case manager realized that her approach to monitoring was inappropriate only after her colleagues indicated so during the interview.

* * *

Family planning and assessment team members in another locality were concerned that the lack of CSA case monitoring guidelines impacted the effectiveness of case monitoring activities. In the locality, case managers were informed to follow the case monitoring requirements that exist for any child coming into the care of their individual child serving agencies. However, team members suggested that they could not be sure that case managers were in compliance with their own required monitoring activities. They would prefer that monitoring controls specific to CSA cases be put in place.

Case monitoring activities are an important piece of utilization management. However, if these activities lack consistency, utilization management practices may be compromised. Although local CSA programs have set up structures for monitoring activities to take place, specifications as to the frequency and breadth of monitoring activities are not always easily identifiable for case managers.

For instance, all multi-agency teams require a designated case manager to provide them with updates on the progress of service recipients. However, these requests are often made on an as-needed basis and are usually totally dependent on the monitoring activities of the case manager. Because the majority of localities in the JLARC subset (55 percent) required no set schedule for multi-agency reviews of children's progress in treatment programs, there is concern over the adequacy of CSA case monitoring activities at the case manager and multi-agency level. The same can be said for local utilization review activities.

Local Utilization Review Policies. With few exceptions, what localities have come to call utilization review policies are more related to case monitoring. Many local officials have suggested that multi-agency reviews of CSA-funded cases are a means by which the quality of services being provided can be assessed. However, utilization review involves more than service plan reviews. Utilization review involves selected individuals, other than case managers, reviewing treatment programs for quality of structure, process, and outcomes. Although it would be appropriate for multi-agency teams to implement utilization review policies, their focus should not be limited to case monitoring practices.

Because the State is currently in the process of establishing utilization review guidelines and procuring utilization review services for local purchase, many localities have opted not to establish their own policies until State guidelines and services become available. Still, localities would have the option of designing and implementing their own utilization review policies. For those localities which chose to design their own utilization review programs, requirements should be in place that ensure these programs contain essential elements of sound utilization review.

However, because few localities had established utilization review policies as a tool for measuring the adequacy and success of CSA utilization management, JLARC

staff also reviewed documentation submitted by the providers of treatment services to CSA children. Information collected from provider file reviews measured the quality of services being provided to CSA recipients.

Review of Provider Files. One common method for performing utilization review of publicly funded service programs is to conduct a comprehensive review of provider documentation by having the reviewer go to the provider's office or by having the provider submit required documentation to the reviewer. The purpose of this type of review is to determine if the child's placement was appropriate, cost-effective, and the services provided matched the child's identified needs. Without utilization review, children may be receiving services that last longer than necessary, that do not match their identified needs, or that cost more than is necessary.

JLARC requested provider documentation from a variety of providers, representing inpatient psychiatric hospitals, residential facilities, therapeutic foster care, day treatment programs, special education programs, and community services, such as in-home and individual mental health counseling services. Each selected provider submitted to JLARC the following information for services provided to a CSA child in State fiscal year 1995: admission and discharge dates; admission diagnoses/reasons; physicians orders; social history; psychiatric evaluations; plans of care; progress notes; and discharge summaries. Information was received for 61 randomly selected children from 41 different providers.

The purpose of the review of provider documentation was to address three questions: First, are the plans of care or treatment plans developed by the private and public providers of services for CSA children appropriate and reflective of the identified needs of the children? Second, does the provider's documented performance of interventions or activities reflect the plan of care? And finally, does the provider effectively communicate the plan of care, the treatment results, and the discharge plans with the local CSA administering units and the family or guardian of the CSA children?

According to basic standards for case management, the development of appropriate care plans or treatment plans should include these standards:

- The care plan should reflect the identified needs of the child.
- The care plan should have goals and objectives that are measurable, and clearly outline the interventions/activities to meet the objectives.
- The expected time frame for each objective should be provided, and the date the objectives are accomplished should be noted.
- The care plan should be developed with input from the child's family/guardian and the CSA agency making the referral.

JLARC staff found considerable variability among providers on the development of appropriate care plans to govern the provision of services (Table 18). Most of the care plans submitted by the residential providers met the basic standards for good care plan development. This may be attributed to the fact that most residential providers have typically received closer scrutiny by outside entities due to their high costs, and therefore they are further along on the development of standards for good record documentation. However, this was not the case with the other providers. Most of the documentation submitted by the community based providers, which includes those providing therapeutic foster care, indicated that the basic aspects of an appropriate plan of care are missing. The care plans of private providers of therapeutic foster care met the basic standards more often than those submitted by public agencies providing this service. Most care plans submitted by all of the providers did have the signature of the family/guardian, and many care plans also had the signature of the appropriate CSA agency. This indicated that at least at the initiation of services, the care plan was reviewed by someone representing the child's interests.

While some providers submitted comprehensive care plans and appropriate documentation demonstrating that the care plan was implemented, most providers did not. As shown in Table 18, 44 percent of the residential providers, 37 percent of the day

Table 18

Review of Provider Plan of Care/Treatment Plans for CSA Children

| Review Questions | Residential Providers (n=19) % appropriate | Day Treatment/Special Education (n=27) % appropriate | Community Based Care/ Therapeutic Foster Care (n=15) % appropriate |
|---|---|---|---|
| Plan reflects admission diagnosis/reason | 89% | 72% | 73% |
| Plan reflects social history | 79% | 32% | 80% |
| Plan reflects psychiatric evaluation | 63% | 48% | 47% |
| Goals/objectives measurable | 89% | 76% | 27% |
| Tasks needed clearly outlined | 89% | 76% | 33% |
| Expected time frame for objectives provided | 84% | 56% | 33% |
| Dates objectives accomplished noted | 44% | 37% | 0% |

Source: JLARC staff analysis of documentation submitted by providers.

treatment/special education providers, and none of the community based care providers indicated the dates when the objectives in the care plan were accomplished. This type of information is usually found in the primary therapists or staff's progress notes. Basic standards for case management indicate that appropriate documentation to demonstrate the implementation of the care plan should include:

- progress notes that document the performance of interventions and activities that reflect the plan of care, whether these interventions were adequate to meet the child's needs and whether any changes were made to these interventions.
- progress notes that document ongoing contact with the family/guardian of the child and the appropriate CSA agency.
- progress notes that document a comprehensive discharge plan, which includes whether the care plan was successful and any transition plans necessary to ensure that the termination of the service is successful.

As shown in Table 19, JLARC staff reviewed the submitted documentation to assess whether the plan of care was effectively carried out by focusing on the documented activities and progress notes reported by staff. Discrepancies between what is stated as the plan of care and what was actually implemented were scrutinized. For example, if the plan of care stated that a child was to receive individual counseling sessions, the submitted documentation was examined to see that those sessions were provided.

For residential type providers, more than half (53 percent) of the progress notes reviewed did not offer sufficient detail to determine whether the interventions/activities described in the plan of care were actually implemented. Community based care providers, including the therapeutic foster care providers, also did not provide adequate documentation. Some of these providers provided progress notes but they were not tied to a specific plan of care. The most serious problems were observed for providers of day treatment and special education services. Typically, more than 80 percent of the progress notes reviewed did not offer satisfactory detail to determine that the plan of care or individualized education plans were carried out as planned.

Adequate discharge planning, especially when children are being returned to the community, should be another integral phase in the services provided to a child. While 78 percent of discharge summary documentation submitted by the residential providers indicated whether or not the plan of care had been achieved, only half indicated that they were successful in achieving the goals of the plan of care. In addition, while the majority (79 percent) of the residential providers maintained some contact with the family/guardian or the CSA agency, it was not apparent that either of these contacts were actively involved during the implementation of the care plan or in the discharge planning. In 24 percent of the cases, the residential provider did not provide documentation which indicated where the child was discharged. During a meeting with representatives of providers, including residential providers, the providers ex-

Table 19

Review of Provider's Primary Therapist/Staff Progress Notes for CSA Children

| Review Questions | Residential Providers (n=19) % appropriate | Day Treatment/Special Education (n=27) % appropriate | Community Based Care/ Therapeutic Foster Care (n=15) % appropriate |
|--|--|---|--|
| Notes document performance of interventions/activities that reflect the plan of care | 47 % | 16 % | 13% |
| Notes document that intervention/activities are adequate to meet the child's needs | 53 % | 20 % | 27 % |
| Notes document when changes are needed to the intervention/activities | 47 % | 20 % | 33 % |
| Notes document contact with the child's family/guardian | 79 % | 68 % | 80 % |
| Notes document contact with a CSA agency | 79 % | 40 % | 73 % |
| Discharge summary documents whether or not plan of care has been achieved | 78 % | 29 % | 64 % |
| Discharge summary documents the treatment plan was successful in achieving goals of the plan of care | 50 % | 33 % | 13 % |
| Discharge summary indicates where the child is discharged to | 76 % | 14 % | 64 % |

Source: JLARC staff analysis of documentation submitted by providers.

pressed the need for the CSA agencies to work more closely with them in the development of the care plan, implementation of the care plan, and discharge planning.

Because significant problems were observed, the adequacy of the local CSA monitoring activities again can be called into question. The provider documentation furnished to JLARC staff indicate that some provider care plans are not adequate, and that many providers are not successful in documenting the provision of services to the CSA child. Since the basic tenet of utilization management is to ensure appropriate placement of the child and the appropriate use of public funds, it is imperative that standards for CSA monitoring activities through case management and utilization review be implemented statewide. It is also evident from this review that the current CSA utilization management initiative, which emphasizes residential providers, would be short sighted if it did not include all types of providers. While residential providers may be the most expensive, this review indicates that other community based providers warrant closer scrutiny.

Recommendation (5). The General Assembly may wish to require that the State Executive Council develop uniform standards for case management to include: initial intake and screening, assessment, development of a plan of care, implementation of the plan of care, service monitoring and periodic follow-up, and formal review of the child's status. These standards should include the need to work with the providers on the development of their care plan, monitoring the progress of the child, and planning for discharge.

Recommendation (6). The General Assembly may wish to require that the State Executive Council develop uniform standards of documentation for CSA-funded services. These standards should ensure that treatment plans reflect the identified needs of the child, that the performance of activities or interventions reflect the care plan, and that the provider communicates with the family/guardian of the child and the appropriate CSA agency.

Recommendation (7). The General Assembly may wish to require that the State Executive Council develop mandatory uniform standards for utilization review for all providers of CSA-funded services.

IV. CSA Caseloads and Participant Costs

When CSA was implemented in 1993, it was expected to slow the rapid cost increases associated with the programs that were previously funded to serve at-risk children, and eliminate some of the problems that were created by the use of multiple categorical funding streams. Previous assessments of the program have concluded that CSA has successfully stabilized the participant costs of services to at-risk children statewide, but experienced unexpected increases in both caseloads and total costs. Furthermore, a review of the per-participant costs for various localities indicates that there is wide variation in these costs across jurisdictions. Accordingly, a major question concerning these trends is whether they are a function of a growing and more difficult to treat population of at-risk children within certain localities, or whether they reflect local program strategies that may not be consistent with CSA's legislative intent.

This study found that the growth in the number of children entering foster care and the number of families receiving food stamps were two of the strongest factors associated with the rise in CSA caseloads from FY 1994 to FY 1996. As the growth in the caseloads for food stamps is correlated with the changes in the poverty rate, and the growth in foster care cases reflects a breakdown in the family structure, in the absence of statute changes to the eligibility criteria for CSA, there is little that local governments can do to minimize the impact of these particular factors on program caseloads.

At the same time, however, it appears that local program implementation strategies do play a significant role in some of CSA's caseload growth. Specifically, the decision by some local governments to provide foster care prevention services to youth without using the multi-agency approach to plan and deliver these services is a key factor in the growth of CSA caseloads statewide. Whether this foster care prevention designation is appropriately applied, as discussed in Chapter III, is an issue that requires much greater State scrutiny than it has presently received.

Also, in terms of the unit or participant costs of CSA, previous conclusions that the statewide average participant costs have stabilized may be premature, as they were based on a flawed analysis. Further, the analysis of local variation in participant costs found that much of the variation in participant costs is explained by factors beyond the localities' control, such as the level of dysfunction exhibited by the children. However, some local implementation policies, such as the use of the multi-agency assessment team for service plan development, do appear to help reduce the participant costs of CSA.

These findings suggest that absent a major policy change to reduce the number of children entering CSA and/or pursuit of alternative funding sources, the total cost of the program for the State will continue to grow. However, both the State and the localities may be able to generate some small cost savings through policies that promote a more efficient delivery of services.

This chapter presents the results from JLARC's staff analysis of statewide CSA caseload and participant cost trends. The focus of this analysis is on whether the changes in the CSA program are a function of factors that can be controlled by localities through how they implement CSA, or alternatively, factors that are beyond the control of local governments.

FACTORS INFLUENCING CHANGES IN CSA CASELOADS STATEWIDE

Between FY 1994 and FY 1996, CSA caseloads and total costs increased by 32 percent and 38 percent, respectively. Prior to this study, the extent to which these rapid caseload and cost increases reflected the impact of larger societal changes or local management practices was unclear. This is important because answers to questions concerning the underlying reasons for the observed program changes hold important implications for efforts to address the program's rising costs.

Some observers of CSA have argued that the primary reason for the program's rising cost is an increase in the size of the State's at-risk youth population due to such factors as poverty. This rise in the number of poor at-risk youth, they contend, has fueled the increases in CSA caseloads and, by extension, program costs. Because the increase in the number of at-risk youth is beyond the control of the local governments that administer CSA, there is little that program administrators can do to curb the rising costs of the program.

In contrast, others have argued that local implementation practices have strongly influenced the growth in CSA caseloads and costs. They note that the General Assembly gave localities broad discretion in implementing and administering the provisions of CSA, and they believe that many localities have defined the CSA eligibility criteria too broadly and given too little attention to systematically controlling program expenditures. As these factors are within the control of local governments, improved administration and management of the CSA are seen as the key to slowing the growth in program caseloads and costs.

The evidence from this study indicates that there may be some merit to both of these positions. On the one hand, two of the most important factors that appear to be influencing the growth in CSA caseloads — changes in the foster care and poverty populations — can not be controlled by the local CSA programs. Moreover, because children in foster care are considered mandated for CSA services, the impact of this factor on total CSA caseloads is both understandable and unavoidable under the current statute.

On the other hand, however, localities appear to be reaching deeper into the pool of the CSA-eligible population to provide services to children that are locally classified as foster care prevention cases. Whether these decisions are justifiably based on local efforts to provide the outreach prevention services emphasized in State statute

depends on the actual risk of the children that are being served by this strategy and the nature of the services they are provided. This is a issue that merits considerably more attention than it has been given at the State and local level.

CSA Caseload Growth Is a Function of Factors that are Both Beyond and Within the Control of Local Programs

Because CSA is designed to serve children who are at-risk of experiencing various emotional, mental, and social problems, one way to predict or explain changes in the size of the program is to examine trends among various at-risk populations or subgroups. The groups examined in this study, which are listed in the top half of Exhibit 2, are considered external to CSA because local program operators have no control over the size, growth rate, and impact that these groups have on their programs. For example, if large increases were to occur in the number of foster care cases, child protective service abuse complaints, or juvenile court intakes, it is likely that CSA administrators would witness an increase in the number of youth seeking and ultimately receiving services through the program.

Exhibit 2

Variables Used in Analysis of CSA Caseload Growth

Independent External Factors (Changes in:)

- Foster care cases
- Private special education placements
- Founded Child Protective Services complaints
- Criminal juvenile court intakes
- Teen pregnancies
- Households receiving food stamps
- Number of youth in poverty
- Median family income

Independent Internal Variables

- Multi-agency review not required for certain CSA-funded services
- FAPT members frequently participate in IEP process for children in private placements
- Juvenile court judges frequently order CSA services

Notes: Special education data are for 12/1/93 to 12/1/95. Teen pregnancy data are for FY1993 to FY1995. Median family income data are for 1994 to 1996. All other data are for FY1994 to FY1996.

Sources: Department of Social Services, Department of Education, Department of Juvenile Justice, Department of Health, United States Census Bureau, and *Virginia Statistical Abstract*.

Notwithstanding the impact of these external factors, local program administrators do have some control over the number of youths that will be served in their programs. As noted earlier, the *Code of Virginia* provides localities with a considerable amount of discretion in deciding how their programs will be administered. CSA, unlike most social welfare programs, is not means tested. Rather, eligibility for many children is determined through a subjective analysis of their emotional state and behavioral patterns. Accordingly, when assessing the eligibility of children, local operators do have the authority to deny services to these individuals, thereby directly influencing the number of persons who enter CSA.

For this study, those local strategies which have the potential to impact the number of persons who receive CSA services were identified and considered endogenous factors because they are within the control of local governments. For example, some localities may require that all persons seeking CSA services appear before a multi-agency team for an assessment of their treatment needs. Some local teams may insist that their CSA multi-agency team be involved in the process through which children from local special education programs are considered for CSA services. Still other localities, in the face of judicial court orders for treatment services, may elect to meet the requirements of the order through CSA rather than some other program. Obviously, decisions of this nature have a direct impact on the size of local CSA programs. The bottom half of Exhibit 2 lists the endogenous or internal variables that were considered in this analysis.

Trend Analysis of Factors Potentially Related to CSA Caseloads. Using existing aggregate local data, CSA caseload data, and information collected from localities regarding various aspects of their CSA programs, JLARC staff analyzed the statewide growth in CSA caseloads between FY 1994 and FY 1996 through the use of a statistical technique, commonly referred to as multiple regression. As a precursor to this analysis, JLARC staff first compared the changes that have occurred in various at-risk populations with the changes observed for CSA caseloads (Table 20).

As shown, the percentage increase in CSA caseloads (32 percent) is substantially larger than comparable changes for each of the exogenous or external factors considered in this study. The three-year percentage change in the increase in the number of foster care cases statewide was the highest observed for all of the factors considered, with a growth rate of 11 percent. While important, this is still substantially less the rate of growth witnessed in CSA caseloads. Juvenile court intakes and private education placements for special education students had the next highest growth rates of seven and six percent respectively.

Regression Analysis of Caseload Growth. These findings raise the possibility that local program strategies (or internal factors) play as much of a role in the observed CSA caseload changes as the previously discussed external factors. To test this theory, the relative influence of both sets of factors on CSA caseload growth was examined by including these two sets of independent variables in the multiple regression model. The dependent variable for the model represented the percentage change

Table 20

Growth in CSA Population and Various At-Risk Groups

| Measure | FY 1994 | FY 1995 | FY 1996 | % Change 1994-1996 |
|--------------------------------------|---------------|---------------|---------------|-----------------------|
| Foster Care Cases | 8,860 | 9,380 | 9,810 | 11% |
| Private Special Education Placements | 1,346 | 1,265 | 1,415 | 5% |
| Founded CPS Complaints | 6,560 | 6,762 | 6,946 | 6% |
| Criminal Juvenile Court Intakes | 89,854 | 98,177 | 95,727 | 7% |
| Food Stamp Recipients | 231,175 | 233,247 | 234,853 | 2% |
| Total Special Education Students | 135,446 | 141,011 | 143,967 | 6% |
| Teen Pregnancies | 6,484 | 6,599 | 6,668 | 3% |
| CSA Caseload | 10,214 | 12,176 | 13,453 | 32% |

Note: Special education data reports the number of students on December 1 of that fiscal year; teen pregnancy data is for FY 1993 to FY 1995.

Source: Department of Social Services, Department of Education, Department of Juvenile Justice, Department of Health, and Office of Comprehensive Services.

in CSA caseloads from FY 1994 to FY 1996. The independent exogenous variables were measured based on the percentage change in the relevant factors from one point in time to another. The local program factors were established as dummy variables with a value of "1" to indicate the local use of a particular strategy. Otherwise the variable had a value of "0".

Table 21 presents the results of this analysis. As shown, the R^2 value for the resulting model was .727, indicating that the model explains almost 73 percent of the variation in caseload growth. With standardized coefficients of at least .220, three independent variables in particular were strongly associated with the observed changes in CSA caseloads in ways that were not counter-intuitive. They were variables measuring: (1) the percentage change in foster care cases, (2) whether localities use a multi-agency review to make foster care prevention services available to CSA applicants, and (3) the percentage change in the number of households receiving food stamps.

The large influence that foster care cases have on overall CSA caseload growth is not surprising. Foster care children are mandated to receive services and make up a majority of CSA-funded cases. As discussed earlier, the number of children receiving foster care maintenance payments through CSA has risen by 11 percent between FY 1994 and FY 1996. In addition, children who receive foster care maintenance payments separately through the federally-funded Title IV-E program can still receive additional services funded through CSA. Moreover, these individuals are counted as a part of the CSA caseload, even when the only funds spent on their behalf are through the federal Title IV-E program.

Table 21

Impact of Several Factors on CSA Caseload Growth

| External Factors | Relationship to Caseload Growth | | |
|---|---------------------------------|--------|------|
| | Standardized Coefficient | Strong | Weak |
| Percent Change in Number of Foster Care Cases | .623 | ✓ | |
| Percent Change in Number of CPS Complaints | -.221 | *✓ | |
| Percent Change in Number of Households on Food Stamps | .216 | ✓ | |
| Percent Change in Number of Juvenile Court Intakes | -.171 | | *✓ |
| Percent Change in Median Family Income | .055 | | ✓ |
| Percent Change in Number of Private Special Education Placements | .048 | | ✓ |
| Percent Change in Number of Teen Pregnancies | -.018 | | *✓ |
| Internal Factors | | | |
| No Multi-Agency Review Required for Foster Care Prevention Cases (1=Yes, 0=No) | .278 | ✓ | |
| No Multi-Agency Review Required for Specialized Foster Care Cases (1=Yes, 0=No) | -.265 | *✓ | |
| No Multi-Agency Review Required for Other Mandated Cases (1=Yes, 0=No) | .138 | | ✓ |
| No Multi-Agency Review Required for Special Education Private Placements (1=Yes, 0=No) | -.044 | | ✓ |
| No Multi-Agency Review Required for Regular Foster Care Cases (1=Yes, 0=No) | .044 | | ✓ |
| Is Multi-Agency Review Now Required for All CSA Services? (1=Yes, 0=No) | .021 | | ✓ |
| Do FAPT Members Frequently Participate in IEP Process for Private Placements? (1=Yes, 0=No) | -.017 | | ✓ |
| Do Juvenile Court Judges Frequently Order CSA Services? (1=Yes, 0=No) | .014 | | ✓ |
| R-Square : .727 n = 88 | | | |

Notes: The dependent variable for this analysis was the percentage change in local CSA caseloads. *The direction of the relationship between the dependent and independent variables represented by these standardized coefficients is counterintuitive, but these variables are included in the model because they had an impact.

Source: JLARC staff analysis of caseload data from the Office of Comprehensive Services and from the JLARC survey of each locality.

The importance of the second variable — whether or not a multi-agency meeting was required for foster care prevention services — indicates that local management practices have a significant influence on CSA caseload growth. As discussed in Chapter I, the goal of the multi-agency approach is to bring human services staff from various local agencies around the table to assess the actual risk of the child referred to CSA and, if required, develop a plan of service based on the child's needs. However, because State statute does not require that all persons referred to CSA appear before the multi-agency team, some localities have given individual caseworkers the authority to unilaterally assess the eligibility of the child and develop the service plan. As children who are categorized as "foster care prevention cases" are considered mandated by State statute, those localities who chose not to set aside dollars to serve non-mandated children can bring some of these youths into CSA as mandated foster care prevention cases.

This analysis clearly indicates that this approach to serving youths under CSA is positively associated with the increases observed in CSA caseloads. Whether this represents an abuse of local discretion can not be determined from aggregate level data. However, officials at the Office of Comprehensive Services and the Department of Social Services have indicated that the issue of foster care prevention under CSA needs greater attention than it has received to date in the program.

The third variable associated with caseload growth is the change in food stamp caseloads. Research has shown that changes in the number of households receiving food stamps have been correlated with changes in the poverty rate. In other words, as more people fall below established poverty thresholds, the number of people seeking food stamps has increased. Thus, as a probable proxy measure for changes in the number of persons living in poverty, the importance of this measure in the model is understandable as well. Children who are poor are more likely to live in environments that feature single-parent households, family dysfunction, economic instability and other factors that increase their chances of developing emotional and behavioral problems. As these types of children represent the intended beneficiaries of CSA services, the relationship observed in Table 21 is to be expected. Since the food stamp measure is a proxy measure for poverty, it should be noted that changes in the underlying eligibility rules for food stamps could reduce its association with CSA caseloads.

Two factors, the lack of multi-agency review for specialized foster care cases and the percent change in the number of Child Protective Services (CPS) complaints, had relatively strong but counterintuitive (negative) relationships with caseload growth. These factors are included in Table 21 to recognize their association with caseloads, but the reason(s) that may account for these counterintuitive effects are not clearly apparent.

VARIATION IN CSA PARTICIPANT COSTS

One of the primary goals of the CSA program was to stem the growth of the costs associated with providing treatment services to at-risk youth. Previous assess-

ments of CSA have indicated that statewide, average participant costs have stabilized as a result of CSA. However, there is tremendous variation in the average costs of serving CSA children from one locality to the next. For example, the average participant costs in the 22 localities examined by JLARC staff in this study ranged from a low of \$933 to a high of \$32,586 in FY 1995.

JLARC staff first examined the statewide CSA cost data collected by the Office of Comprehensive Services to determine if the per-child treatment costs of CSA have indeed stabilized. As a result of this analysis, JLARC staff found that assertions of stable CSA participant costs across the State are based on flawed analysis. Specifically, because the Office of Comprehensive Services includes children receiving only foster care maintenance payments in its determination of CSA treatment costs, the true per-participant costs of treatment services have been deflated.

To examine the local variation that exists in CSA participant costs across the State, JLARC staff utilized individual data collected from the subset of localities. In theory, the level of dysfunction exhibited by the child, which is entirely out of the control of the localities, should be the most significant factor contributing to the cost for that child. However, due to the flexibility allowed localities in implementing CSA, it is possible that factors within their control, such as local policies governing the implementation of CSA, can contribute significantly to participant costs. For these reasons, factors both within and outside of local control have been examined for their impact on CSA participant costs.

From the analysis of the variation in participant costs of CSA, JLARC staff found that high-cost localities generally exhibit certain characteristics that separate them from localities classified as low-cost. For example, high-cost localities are less likely to be experiencing fiscal stress, more likely to serve a larger proportion of children with serious risks, less likely to be rural, and tend to have wealthier residents and residents with a higher level of education. High-cost localities also differ from low-cost localities on the most fundamental aspects of CSA. Specifically, high-cost localities were less likely to use the multi-agency approach to develop service plans for CSA children and were more likely to provide a level of service that exceeded the needs of the child. However, when the effect of multiple factors on the costs of serving youth in CSA were simultaneously considered, the largest impacts were observed for those factors that were beyond the control of local officials.

These findings point out three significant facts about CSA costs. First, assertions that CSA has reduced the per-participant costs of services for at-risk youth across the Commonwealth not only cannot be confirmed, but should be questioned as well. Second, some of the key factors that appear to increase the participant cost of serving children through CSA have little to do with the methods used by local governments to implement the program. These factors - - such as the risk of the child - - underscore the difficulty that will accompany any effort to substantially lower CSA participant costs without reducing services to children with considerable risk. Finally, the fact that high costs appear to be associated with service planning that occurs outside of the CSA

multi-agency process, especially for those children who receive special education services, indicates that broader use of the multi-agency assessment process may provide opportunities for some cost savings in the program.

Conclusions that CSA Has Stabilized Unit Costs May Be Premature

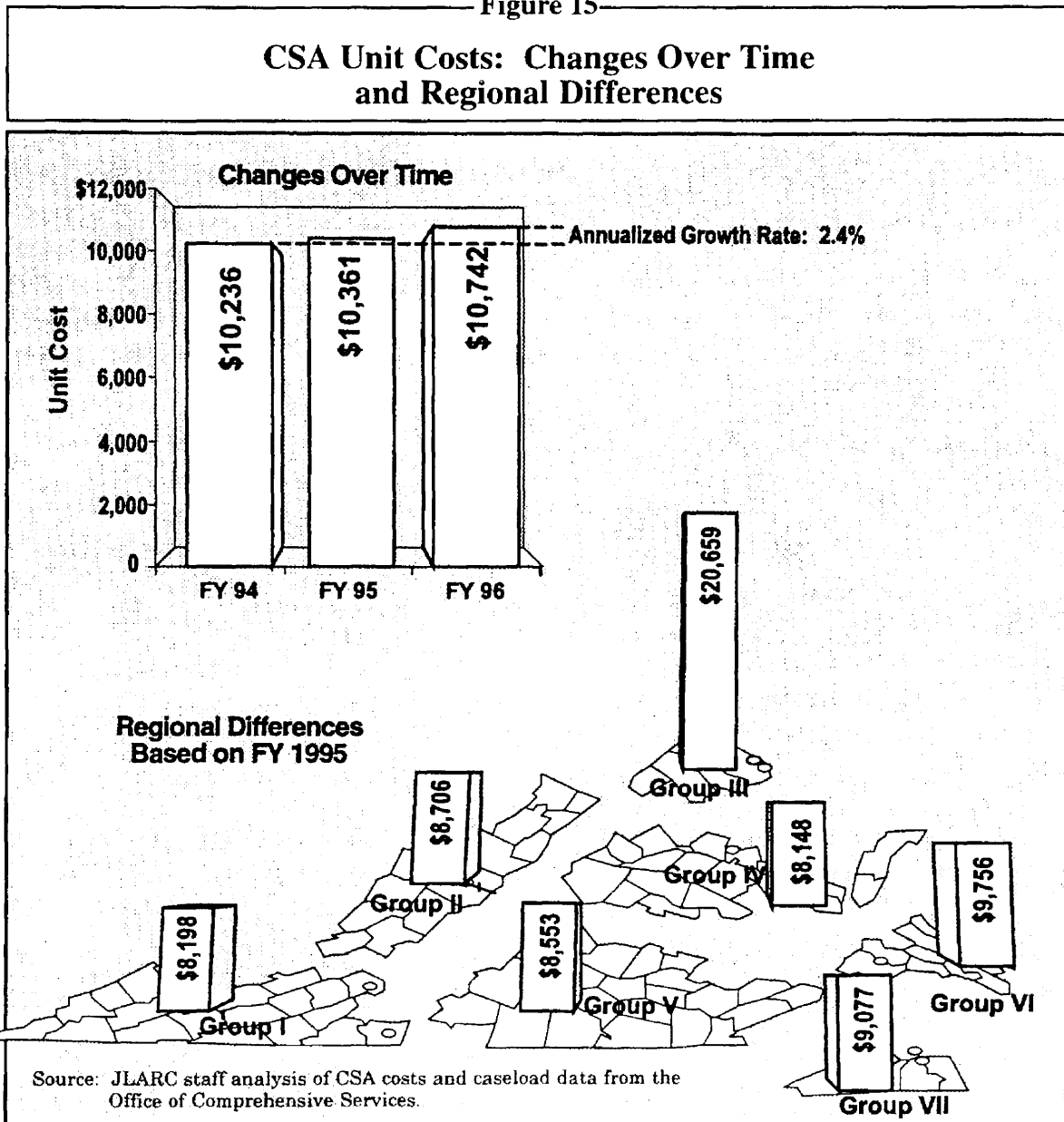
One aspect of CSA which has drawn considerable praise is the limited growth that has been reported in the program's per-unit or average cost. From FY 1994 to FY 1996, the per-child cost for CSA statewide was reported to have increased by slightly less than five percent — an average annual increase of about 2.4 percent. Even on a regional basis, differences in the unit costs of the program were relatively low except in Northern Virginia (Figure 15). While attempting to use the statewide cost data to explain the variation in participant costs, JLARC staff were unable to develop a cost model which effectively explained the changes in this variable. This was due to the lack of variation in the statewide average cost per child. Although a number of different models were tested, none could explain more than 30 percent of the variation in unit cost. However, individualized participant data collected through file reviews in a subset of localities reviewed for this study was utilized to examine those factors which appear to be associated with the variation in participant costs.

Problems with CSA Unit Cost Measure. Although the per-child costs for the programs which served at-risk children prior to the establishment of CSA were never determined, DPB staff concluded from its study of this system that provider rate increases were a factor in the rising cost of services to at-risk children. Later, when the relatively flat three-year trend in unit cost was reported for CSA, the conclusion that CSA had effectively slowed the growth in the average cost of serving at-risk children was logically drawn.

However, a closer examination of the data from which these figures were derived reveals one key problem. In determining the number of cases to be included in the denominator for calculating unit costs, the Office of Comprehensive Services counted all foster care cases. This was done because children in foster care are considered mandated CSA cases even if they do not receive treatment services.

The problem with this approach is that a substantial number of these cases are straight foster cases in which no CSA-funded services other than a foster care maintenance payment are provided. For example, when a child is removed from an abusive home environment and placed with a foster family under the current system, the family receives a monthly payment based on State guidelines. The maximum amount of this payment is \$390. Further, in some cases, up to 50 percent of this maintenance payment is paid by federal dollars through the Title IV-E program. If the foster child does not exhibit any emotional, behavioral, or educational problems, he or she will not receive any type of treatment services. Accordingly, in its study of pre-CSA programs for at-risk children, DPB excluded foster care cases that did not involve a residential placement outside of the foster home in which they lived.

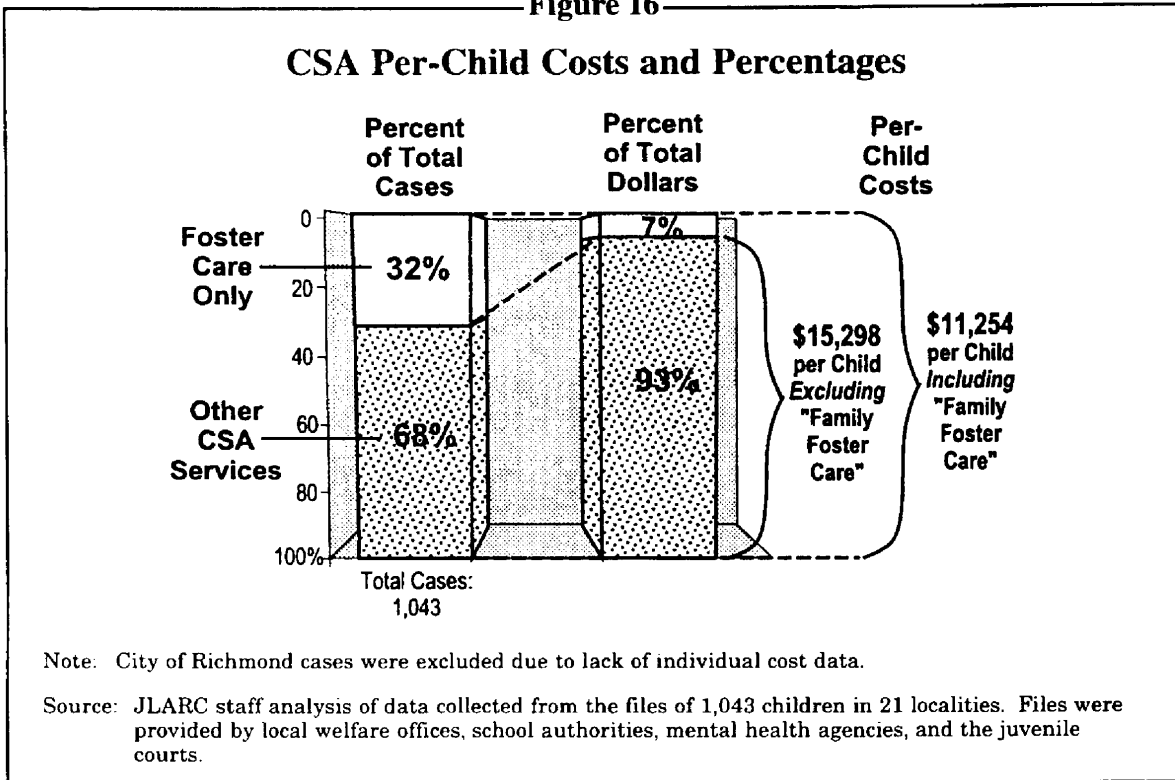
Figure 15



By including these cases in its analysis of CSA unit cost, the Office of Comprehensive Services appears to have seriously understated the actual per-child cost of providing treatment to at-risk children. Using data collected from the files of over 1,000 children in CSA, JLARC staff determined that almost one-third of the CSA caseload consisted of “family foster care” cases (Figure 16). Because they did not receive any treatment services, these children accounted for only seven percent of the total costs of CSA observed for the study sample in FY 1995.

When these cases are excluded from the number used to calculate the per-child costs of treatment services for children with emotional or behavioral problems,

Figure 16



there is a precipitous increase in CSA unit costs. Specifically, these per-child costs rise from \$11,254 to \$15,298 – an increase of about 36 percent. If the rate of increase for family foster care cases from FY 1994 to FY 1996 was greater than the rate for children who received treatment — a distinct possibility given the rise in the number of foster care cases in general — it is likely that the reported figures for CSA unit cost may be increasing rather than stabilizing over time.

High-Cost Localities Exhibit Different Characteristics Than Low-Cost Localities

In order to examine the variation in average unit costs across localities that otherwise seem similar, JLARC staff separated the 22 localities chosen for further study into two groups: those with high average participant cost and those with low average participant cost. As discussed in Chapter I, average unit costs for each locality were created by totaling the CSA dollars spent on each child in the locality's sample in FY 1995 and dividing this by the number of files reviewed in each locality. Once the locality average unit costs were developed, the average unit cost of the 22 localities as a whole was used as the cut-off point – localities below the average are low-cost and localities above the average are high-cost. Table 22 shows the resulting breakout of the 22 localities reviewed by JLARC staff. Both the high-cost and low-cost locality groups were examined for relationships with various locality and participant demographic indicators, such as the education levels of the communities or age of the children. The

Table 22

**Classification of Localities According to
Their CSA Average Participant Cost**

| Low-Cost Localities | | High-Cost Localities | |
|------------------------|------------------|------------------------|-----------------------|
| Patrick County | Hanover County | City of Virginia Beach | Arlington County |
| City of Martinsville | Nelson County | Henrico County | City of Alexandria |
| City of Fredericksburg | City of Norfolk | Dinwiddie County | Chesterfield County |
| Grayson County | City of Hampton | City of Roanoke | Fairfax/Falls Church* |
| Campbell County | City of Richmond | Montgomery County | Shenandoah County |
| City of Staunton | | Westmoreland County | |

Note: Fairfax/Falls Church includes the City of Fairfax, Fairfax County, and the City of Falls Church.

Source: JLARC staff analysis of FY 1995 total costs of the randomly selected children in each locality divided by the total number of files reviewed in that locality.

two locality cost groupings were also examined for relationships with various measures of local CSA implementation practices.

Locality And Participant Demographics. The first step in this analysis was to determine if localities with high participant costs could be distinguished from those with low participant costs in terms of certain socio-demographic characteristics and the basic characteristics of their CSA participants. Table 23 presents the results of this analysis.

As indicated from these results, the demographics of the children served by the local CSA program show some patterns differentiating high-cost localities from low-cost localities. Specifically, high-cost localities appear to have served a higher proportion of females than did low-cost localities. High-cost localities also appear to have served an older population, on average, than low-cost localities. This may indicate that females are more expensive to serve than males, and that the older a child gets, the more costly the child becomes to CSA. It should also be noted that low-cost localities appear to have served a greater proportion of black children than did high-cost localities. This may be explained by the fact that low-cost localities served a much higher proportion of children receiving foster care maintenance payments only, and 70 percent of this CSA sub-group were black.

Also apparent from Table 23, the locality-wide demographic indicators show patterns which distinguish high and low-cost localities. Specifically, a slightly higher percentage of the low-cost localities were rural (10 percent) as compared to the high-cost localities (5 percent). A higher percentage of the high-cost localities were suburban (12 percent) as compared to the low-cost localities (4 percent). This may be influenced by the fact that children from rural communities made up only 7 percent of the

Table 23

**Associations Observed Between Demographic Indicators
and Average Participant Cost Ranges**

| Demographic Indicators | Low-Cost Localities | High-Cost Localities |
|--|---------------------|----------------------|
| Gender of the Child (n=1,134): - male - female | 62% 38% | 55% 45% |
| Age of the Child (n=1,136): - age 10 or below - older than 10 | 46% 54% | 39% 61% |
| Race of the Child (n=1,139): - white - black - other | 28% 67% 6% | 47% 42% 11% |
| Level of Urbanization (n=1,144): - urban - suburban - rural | 85% 4% 10% | 84% 12% 5% |
| Per-Capita Income of Locality (n=1,144): - less than \$25,000 - more than \$25,000 | 59% 41% | 36% 64% |
| Percentage of High School Graduates Residing in the Locality (n=1,144): - less than 70 percent - more than 70 percent | 49% 51% | 14% 86% |

Notes: Based on a Chi-square test, these differences were significant at a .05 level of significance for all variables listed. The level of urbanization is based on population density statistics.

Source: JLARC staff analysis of CSA participant level database.

sample overall, and children from suburban communities made up only 9 percent of the sample overall.

Sharp differences between the participant cost ranges were apparent in the per-capita income and educational attainment levels of the localities. For low-cost localities, the majority of the localities (59 percent) had less than \$25,000 in per-capita income. In contrast, the majority of high-cost localities (64 percent) had per-capita incomes of greater than \$25,000. For educational attainment, 70 percent or more of the population were high school graduates in only half of the low-cost localities. This is significantly lower than the rate of high school graduates observed for high-cost localities, where 70 percent or more of the population were high school graduates in the large majority of the localities (86 percent). One possible explanation for this was voiced by staff from Fairfax/Falls Church, one of the high-cost localities. According to

Fairfax staff, jurisdictions with a more highly educated public must meet higher service expectations, as the wealthier, more highly educated public is more aware of service options, and may have certain advantages in advocating their children's needs.

The Level of Dysfunction Among CSA Participants. Because the costs associated with services generally increase as the service becomes more intense, the level of dysfunction exhibited by the child and the level of service provided to the child should show significant patterns across high-cost and low-cost localities. To determine if high-cost localities serve a greater proportion of high risk children, the risk level of the child (as determined by the Childhood Severity of Psychiatric Illness ratings) was examined for the two groups of jurisdictions. In addition, the child's pre-CSA service history, the actual service level provided, and the source of the referral to CSA were explored for possible relationships to the participant costs of CSA. The results of this examination are presented in Table 24.

Table 24 shows that low-cost localities generally served children with lower levels of risk than did high-cost localities. Specifically, 71 percent of the children in low-cost localities were either "no risk" or had only a "history of risk". Comparatively, 65 percent of the children in high-cost localities were at these risk levels. As another indicator of the child's dysfunction, it is apparent that high-cost localities referred a higher proportion of children (42 percent) to CSA who previously received similar services through other means than did low-cost localities (27 percent).

Also apparent from Table 24, high-cost localities, as expected, provided more of the high dollar services than did the low-cost localities. Only 14 percent of the children in low-cost localities were receiving specialized foster care or day schools/treatment, compared to 27 percent of the children in high-cost localities. Similarly, only 13 percent of the children in low-cost localities were placed in residential treatment facilities, compared to 23 percent of the children in high-cost localities. In fact, half of the children served in the low-cost localities received nothing more than foster care maintenance payments, compared to 24 percent in the high-cost localities.

Analysis of the CSA referral source shows that high-cost localities serve a higher proportion (17 percent) of children referred by local school divisions than do low-cost localities (7 percent). This is significant because JLARC staff found that special education services funded through CSA are more expensive, on average, than the majority of other services funded through CSA. On the other hand, low-cost localities serve a slightly higher proportion (12 percent) of children referred from local Court Service Units than do high-cost localities (8 percent). This result may indicate that localities generally spend less on children referred by local Court Service Units, 74 percent of which were considered non-mandated by the 22 localities. As expected, low-cost localities serve a slightly higher proportion (76 percent) of children referred from local Departments of Social Services than do high-cost localities (70 percent).

Variation in Local Implementation Policies. As described earlier in this chapter, CSA implementation policies vary substantially across the 22 localities examined by JLARC staff. It is possible, therefore, that certain implementation policies may

Table 24

Associations Observed Between Client Dysfunction Characteristics and Average Participant Cost Ranges

| Client Dysfunction Characteristics | Low-Cost Localities | High-Cost Localities |
|--|---------------------|----------------------|
| Risk Level of the Child (n=1,112): | | |
| - no risk | 60% | 54% |
| - history of risk | 11% | 11% |
| - recent risk | 14% | 24% |
| - acute risk | 14% | 11% |
| Did the Child Receive CSA-Type Services Prior to the Referral to CSA (n=1,125): | | |
| - yes | 27% | 42% |
| - no | 73% | 58% |
| Level of CSA Service Provided (n=1,142): | | |
| - family foster care only | 50% | 24% |
| - outpatient counseling | 18% | 13% |
| - community wrap-around | 4% | 9% |
| - specialized foster care and/or day schools/treatment | 14% | 27% |
| - residential treatment | 13% | 23% |
| - psychiatric hospitalization | 3% | 3% |
| Source of the CSA Referral (n=1,136): | | |
| - Department of Social Services | 76% | 70% |
| - Department of Education | 7% | 17% |
| - Community Service Board | 4% | 4% |
| - Court Service Unit | 12% | 8% |
| - Other | 1% | 0% |

Notes: These differences were significant at a .05 level of significance for all variables listed; Children receiving foster care maintenance payments only were included in the "no risk" population.

Source: JLARC staff analysis of CSA participant level database.

be impacting the participant costs of CSA. In order to examine this potential cost impact, certain indicators of local CSA implementation policies were examined for associations with the two groups of localities. Table 25 identifies the policies that were included in this analysis and summarizes the results.

As Table 25 indicates, while nearly half of the children in low-cost localities (49 percent) were reviewed by the locality's multi-agency team, only 43 percent of the cases in the high-cost localities were reviewed. This may indicate that the multi-agency approach envisioned by CSA is working to reduce participant costs.

One issue concerning the growth in CSA costs and caseloads identified through local interviews was the prevalence of mandating all special education children referred to CSA regardless of their need for private tuition services (the only special

Table 25

Associations Between CSA Implementation Practices and Participant Cost Ranges

| Local Practices | Low-Cost Localities | High-Cost Localities |
|--|------------------------|-------------------------|
| Was the Child Reviewed by the Locality's Multi-Agency Team Prior to Receiving Services (n=1,144): - yes - no | 49% 51% | 43% 57% |
| Are All CSA Special Education Children Considered Mandated Regardless of the Private Tuition Requirement (n=146): - yes - no | 97% 3% | 51% 49% |
| Is the Locality's Multi-Agency Team Involved in IEP Development for CSA Special Education Children (n=146): - yes - no | 21% 79% | 0% 100% |
| Does the Locality Require Specialized Foster Care Children to Go Before the Multi-Agency Team Prior to Service Provision (n=248): - yes - no | 99% 1% | 14% 86% |
| Does the Locality Require Children Mandated Through Foster Care Prevention to Go Before the Multi-Agency Team Prior to Service Provision (n=103): - yes - no | 59% 41% | 34% 66% |
| Did the Locality Exhibit Fiscal Stress as Measured by its Fiscal Stress Index Score (n=1,144): - yes - no | 91% 9% | 31% 69% |
| Was the Child's Need Mismatched to the Level of CSA Service Provided (n=1,011): - High Service Predicted, Low Service Received - Low Service Predicted, High Service Received - Service and Need Matched | 21% 6% 74% | 21% 12% 67% |

Notes: These differences were significant at a .05 level of significance. A locality in fiscal stress is defined as a locality with a fiscal stress index score above the statewide average. Children receiving foster care maintenance payments only were included in the "service and need matched" population.

Source: JLARC staff analysis of participant level database. Fiscal stress index scores provided by the Commission on Local Government.

education category defined as mandated by the *Code of Virginia*, §2.1-757). Another issue concerning special education was the input that a locality's CSA multi-agency team had in the development of the Individualized Education Plan (IEP) for the children sent to CSA for funding. As noted earlier, once a service is in an IEP, federal law

requires that service to be provided. Therefore, if the CSA multi-agency team had no role in the development of the IEP, any service planning conducted for these children after the fact is essentially meaningless.

To examine these issues and their influence on participant cost, JLARC staff focused on children referred to CSA by local school divisions. Virtually all of the children in low-cost localities (97 percent) referred by local school divisions were mandated for CSA services regardless of their need for private tuition payments. In high-cost localities, only 51 percent were mandated. Although low-cost localities were involved in the IEP development only 21 percent of the time, none of the high-cost localities had input in the IEP process. This may indicate that the non-private tuition special education children in CSA are relatively inexpensive, and the low-cost localities are serving more of these children than the high-cost localities. The data also indicate that if the multi-agency team were included in the IEP, it is possible that CSA costs associated with those children could be reduced.

Of the small number of children in the JLARC sample that were mandated for CSA services through the designation of Foster Care Prevention, low-cost localities required that they appear before a multi-agency team 59 percent of the time. High-cost localities, on the other hand, only required this 34 percent of the time. Of the children in the JLARC sample receiving therapeutic or specialized foster care, low-cost localities required that they appear before the multi-agency team 99 percent of the time. High-cost localities required this only 14 percent of the time. Both of these results may again add strength to the argument that the multi-agency approach, when implemented, has helped to reduce participant costs.

The fiscal stress of a locality, as it applies to CSA, serves as a measure of the locality's ability to tap other funds when local CSA dollars run out. Fiscal stress is a measurement of the locality's revenue capacity (potential revenue based on statewide average tax rates), and its effort toward meeting this revenue potential. If a locality is experiencing a tight budget, and other revenue sources are unavailable, the locality may not set as high a priority on CSA spending as would a locality with a budget surplus. For this reason, the fiscal stress index of the 22 localities examined by JLARC staff was also examined for patterns within the high and low-cost localities. As Table 25 shows, 91 percent of the low-cost localities were experiencing fiscal stress (an index score above the State average) in FY 1995. Comparatively, only 31 percent of the high-cost localities were experiencing fiscal stress.

The final local implementation practice examined was the locality's ability to correctly match the child's level of need (as determined by the CSPI) to the level of service suggested by those needs. In both participant cost ranges, localities appeared to provide children with high assessed needs with services that were less restrictive than suggested by those needs 21 percent of the time. However, in terms of children that were provided services that were more restrictive than suggested by the level of assessed needs, high-cost localities provided more intense services 12 percent of the time, compared to low-cost localities who did this only 6 percent of the time. This

shows that high-cost localities may be increasing their cost in part by providing a higher service than needed in some cases.

While these results provide valuable insight as to what factors may be influencing the participant costs of CSA, it is important to note that the associations observed in this analysis are uncontrolled. That is, in assessing the relationship between whether a locality has high or low participant costs, and for example, whether it serves a higher proportion of children with more serious risks, the effects of other factors influencing the cost have not been simultaneously accounted for. This type of analysis, which is presented in the next portion of this chapter, identifies which factors are most important in explaining local variation in CSA participant costs.

While the Child's Level of Dysfunction Has the Most Influence on Cost, Some Key Factors Influencing Costs Can Be Controlled by Localities

In order to develop recommendations for possible cost containment strategies for CSA, JLARC staff first had to examine to what extent participant costs were influenced by implementation decisions made by the localities (internal factors) and to what extent these costs were influenced by factors such as the child's dysfunction, which are beyond a locality's control (external factors). If, for example, participant cost is determined entirely by external factors, there is little that can be done through local implementation best practices to reduce cost. On the other hand, if any local policies appear to influence cost, these can be replicated or avoided in order to reduce CSA participant cost.

To conduct this analysis, multiple regression techniques were used to identify the combination of external and internal factors which best explain the local variation in CSA participant costs. The dependent variable used in the regression model was the individual total cost of providing CSA treatment services to each child in the JLARC sample. This total was based on the first fiscal year for which the child received a CSA-funded treatment service (for children who received foster care maintenance only, the total for the first year of maintenance payments was utilized). Because it was anticipated that the total cost for each child would be strongly associated with the length of time that they received a CSA service, a variable measuring length of stay in the program was included in the model. This made it possible to discern whether any additional variation in participant cost could be explained by the other external and internal factors that were explicitly considered in the model.

The regression model developed for this analysis explained 51 percent of the variation in CSA participant costs (as indicated by the adjusted R^2). The model shows that much of the variation in participant cost is explained by variables unrelated to local CSA implementation practices. However, the model did indicate that CSA costs are influenced, at least at the margin, by some practices utilized by the localities. Table 26 presents the external and internal variables that had significant effects on participant cost, while accounting for the length of time that the child received the service. The length of time that a child received the service (which explains about 13 percent of

Table 26

**Factors That Significantly Impact Individual Participant Costs
(Strongest Impact to Weakest Impact)**

| External Factors | Standardized Coefficient |
|---|---------------------------------|
| Child Classified As Having Recent Risk | .318 |
| Child Classified As Having Acute Risk | .297 |
| Child Classified As Having a History of Risk | .193 |
| Child Had Received CSA-Type Services Prior to CSA | .131 |
| Percentage of High School Graduates in the Locality* | .130 |
| Child Referred from Local Department of Education | .102 |
| The Age of the Child | .093 |
| The Sex of the Child (0=Female, 1=Male) | -.055 |
| Child Referred from Local Community Services Board* | .040 |
| Internal Factors | |
| Proportion of Special Education Children Appearing Before a Multi-Agency Team in the Locality | .244 |
| If the Locality Provided a Lower Level of Service than the Level Predicted by the CSPI | -.124 |
| If the Locality Provided a Higher Level of Service than the Level Predicted by the CSPI | .106 |
| Proportion of All CSA Children Appearing Before a Multi-Agency Team in the Locality | -.102 |
| Adjusted R²: .513 n = 997 | |

Notes: The dependent variable for this analysis was the total CSA cost for each child in the sample for the first fiscal year in which the child received CSA treatment services (the first year of foster care maintenance payments for those CSA participant only receiving foster care). All variables were statistically significant at a .05 level of significance, except for those denoted with a *, which were statistically significant at the .10 level of significance. The variable representing length of service, not listed above, had a statistically significant (.05 level) coefficient of .356. Data were weighted based on each locality's proportion of total CSA caseload.

Source: JLARC staff analysis of individual participant data collected through file review and locality demographic data as published in the 1996-97 edition of the *Virginia Statistical Abstract*.

the variation in participant costs) could be due to a combination of both external factors (for example, the risk of the child) and internal factors (such as whether cases are managed as well as they could be).

The Impact of External Factors. The regression analysis of participant cost indicated that many of the key factors that are independently associated with CSA participant costs are beyond the control of the localities implementing CSA. These factors, in conjunction with the length of stay, explained 47 percent of the variation in

participant costs. As expected, the model indicates that as the risk level of a child increases from an assessment of no risk, the participant cost increases as well. In fact, the highest two levels of risk, recent or acute risk, exhibited the strongest positive influence on participant cost in the entire model (excluding length of service). Even having only a history of risk still had a significant positive effect on participant cost. This confirms the underlying assumption that the level of dysfunction exhibited by the child is the most significant factor contributing to the cost of the child, controlling for length of service.

The other indication of dysfunction that had a significant impact on participant costs was the indication of whether the child had been provided CSA-type services through some other means prior to being referred to CSA. The coefficient associated with this variable indicated that those that had received prior services were more expensive on average than those that did not have any prior services before coming to CSA. This tends to further confirm the assumption that children with more dysfunction, or a longer history of dysfunction, require more intense, and more expensive services.

The variable representing the percentage of high school graduates in the locality's population also had a significant effect on participant cost, and in a positive direction. Thus, after controlling for other factors, there does appear to be a relationship between a highly educated citizenry and higher costs associated with the CSA participants. As indicated by staff from Fairfax/Falls Church, this may mean that a more highly educated public has higher service expectations and are more willing or able to advocate for those services.

The coefficients associated with the variables indicating the referral sources of the CSA participants also confirmed one of the tentative conclusions reached in the analysis of the high-cost and low-cost locality groupings. A child referred to CSA from a local Department of Education was more expensive than the rest of the CSA population, indicating that educational services are more expensive to provide, on average. Although not found in the analysis of the locality cost groupings, it appears that children referred by local Community Service Boards are also more expensive, on average, than the majority of the CSA population.

The final two external variables that showed a statistically significant relationship to participant costs were age and gender. While the effect of these two variables are slight, according to the size of the coefficients, the regression did confirm that females, on average, are more expensive to serve, and that generally, the older a child is, the more expensive that child will be.

Impact of Local CSA Implementation Practices. The variables measuring local CSA implementation policies were also included in the regression of individual participant costs. When the local implementation factors that were significant were added to the model, they increased the explanatory power of the model by about four percentage points. The results from this analysis show that while the effects are generally smaller, some local policy decisions do impact the participant costs of CSA.

As Table 26 indicates, four local implementation factors exhibited these relatively small, but significant effects on CSA participant cost.

The strongest influence on participant cost among the local implementation factors was the proportion of a locality's special education children that were seen by a multi-agency team. At first glance, the regression coefficient for this variable indicates that utilizing the multi-agency team approach for special education children significantly increases the costs associated with those children. However, 95 percent of the children's case files examined by JLARC staff were in localities that indicated that the multi-agency team did not have access to the Individualized Education Plan (IEP) development. When a particular service need is expressed in the IEP, federal law requires that the service be provided. Thus, when a special education child is referred to a CSA multi-agency team with an IEP already developed, the multi-agency team review is merely perfunctory. This means that this variable does not indicate the cost effect of the multi-agency assessment for special education children. Rather, it may simply be another indication that special education services are more expensive on average to provide, particularly when CSA is expected to pay for all services in the IEP rather than those related to the education of the child.

Perhaps a better measure of the utility of the multi-agency assessment process is found in the coefficient of the variable representing the overall proportion of children appearing before the local multi-agency team for each locality. While the impact of this variable is fairly slight, it is important to note that the direction is negative, indicating that the more a locality utilizes multi-agency assessment, the lower CSA costs will be. This tends to support the conclusions of the analysis of the high-cost and low-cost locality groupings discussed previously, and indicates that the multi-agency involvement in service planning, which was the cornerstone of the CSA design, has the potential to produce some marginal cost savings for the program if utilized by the localities.

The final local CSA practice that had a statistically significant influence on participant costs was the locality's ability to match the level of service to the apparent needs of the child. As expected, participant costs do rise and fall when services are not appropriate for the needs of the children. If a child received a higher service level than predicted by the algorithm used to assess their needs, participant costs increased. If a child received a lower service level than predicted, participant costs decreased. While these results are to be expected, they nonetheless underscore the need for a uniform assessment process executed by the local CSA multi-agency teams. While it is unclear if actual cost savings would be achieved, the process would increase the likelihood that children in CSA would receive the appropriate services given their assessed needs.

CONCLUSION

The analysis of the factors contributing to CSA caseloads and participant costs indicates that any changes in the way localities implement CSA will have only marginal cost containment effects on CSA. This is not to say, however, that the small economies realized through changes in the ways localities implement CSA are not worth pursuing.

Both caseload growth and participant cost increases appear to be partially the result of the exclusion of certain cases from the multi-agency team assessment process. This coordination of service planning among the local human resource agencies was one of the basic tenets of the original CSA program design, and based on this analysis, it appears that this process has merit as it relates to cost containment. Use of a standard assessment tool for CSA participants has the potential for cost savings, and at the very least will enhance program efficiency. Also, the negotiation of treatment service rates with residential providers, to be discussed in detail in the following chapter, has the potential to reduce CSA costs somewhat.

While these implementation strategies embrace the original intent of the CSA statute and will promote a more efficient program, the largest contributions to the rising CSA caseloads and costs are factors such as the increased number of children in foster care and the intensity of the dysfunction exhibited by the youth population. Because these factors are beyond the control of localities implementing CSA, major cost containment of the program costs for the State can only be realized through statutory changes regarding program eligibility among the Commonwealth's youth, and/or through pursuit of alternative funding sources.

V. CSA Program and Participant Outcomes

When CSA was established in 1993, its focus on local flexibility in the design of community-based programs and the development of a public-private partnership to treat at-risk children was clearly outlined in the Virginia Acts of Assembly. By embracing these concepts, the General Assembly sought to remove what were believed to be long-standing barriers to creative and effective treatment programming for children with emotional and behavioral problems. Additionally, localities were encouraged to increase family involvement in service planning and management, and develop treatment plans which ensured that the mandate to deliver services in the least restrictive environment would be fulfilled.

This chapter of the study assesses the CSA program on two different types of outcomes. The first is programmatic outcomes which focus on whether the legislative program goals for CSA — family involvement and the provision of services in the least restrictive environment — are being met. The second is participant outcomes which concern the type of adjustment that CSA participants appear to be making since receiving the treatment services that were funded through the program.

Using several measures of program performance, it appears that local program staff have responded to the legislative mandate to move the treatment for at-risk youth to less restrictive settings. For those who were initially placed in a more restrictive setting, the data from this study show that many were later returned to the community, presumably after their behavior stabilized. Most encouraging were findings from a survey of the guardians of these children. About 70 percent of those surveyed agreed that they were adequately involved in the CSA service planning process, and indicated that the program helped to improve their child's behavior.

Still, there are reasons for concern. While community treatment appears appropriate for many children in CSA, there are some youths who do not appear to respond to this model. Although this group of children is small in number, they tend to have much longer periods of treatment and are likely one of the primary reasons that the average daily cost of the program for a cohort of children in CSA show significant increases over time.

While there are no easy solutions to developing treatment plans for children with chronic emotional and behavior problems, local CSA staff must resist the temptation to lower the cost of care for this population by simply reducing the level of their placement. While such an approach will likely generate short-term reductions in the cost of serving this population, the long-term effect may be a higher future cost when these children return to CSA with problems that were never properly addressed.

A more cost-effective alternative for local jurisdictions would be to develop strategies to negotiate lower rates with the vendors who provide services to this population. The cost data collected for this study indicate that local CSA programs have paid substantially higher amounts for treatment services over the last four years. While

these cost increases were evident among providers across all treatment settings, the most pronounced growth was observed for residential facilities.

TREATMENT SETTINGS FOR CHILDREN IN CSA

There is widespread agreement among mental health professionals that children who have emotional and/or behavior problems are better served when the treatment they require is delivered in the least restrictive environment possible. As this is the basic tenant of CSA, the initial focus of this analysis was on how effective local CSA staff have been in moving CSA's at-risk population into community-based treatment.

The results of this analysis indicate that CSA staff have pursued the treatment of at-risk children in the program through community-based initiatives. Approximately seven out of 10 children were placed in community programs at the time of their first referral to the program. This rate of community placement was generally achieved even for children who came to CSA from the more restrictive settings of acute care hospital units. Also, relative to the first service they received through CSA, the data from this study show that the portion of children moving into a less restrictive environment generally increases the longer they remain in the program.

There are, however, some children whose treatment needs do not appear to be compatible with the service philosophy of CSA. For these children, it appears that the decisions to place them in the community were often reversed because of continuing behavior problems. Others in this population remained in high cost settings because of their failure to demonstrate the behaviors required for community placements. As an example, about 23 percent of the youths in this study were placed and consistently maintained in more restrictive and costly program settings during their stay in CSA.

Due mostly to the disproportionate impact that this group has on program expenditures, the daily cost of treating a given cohort of children under CSA has actually increased. For example, in the two years since they first received CSA-funded treatment services in FY 1995, the costs of the care for this cohort of children has almost doubled. One factor in these cost increases are the higher costs localities face from providers. Over this same two-year period, localities have faced cost increases of nearly 60 percent when purchasing residential treatment services. The cost of residential care for youths who entered CSA in FY 1994 and left the program in FY 1997 increased by 132 percent. Clearly local governments will need to do a better job of negotiating rates for future placements if these costs are to be controlled.

Local CSA Staff Have Shifted CSA Treatment Into Less Restrictive Environments

One of the hallmarks of CSA is its specific charge that local staff work to utilize outpatient or community-based services when brokering treatment for CSA

participants. As a result, the initial phase of this analysis focused on the degree to which CSA participants are being placed in the type of treatment settings envisioned by State statute.

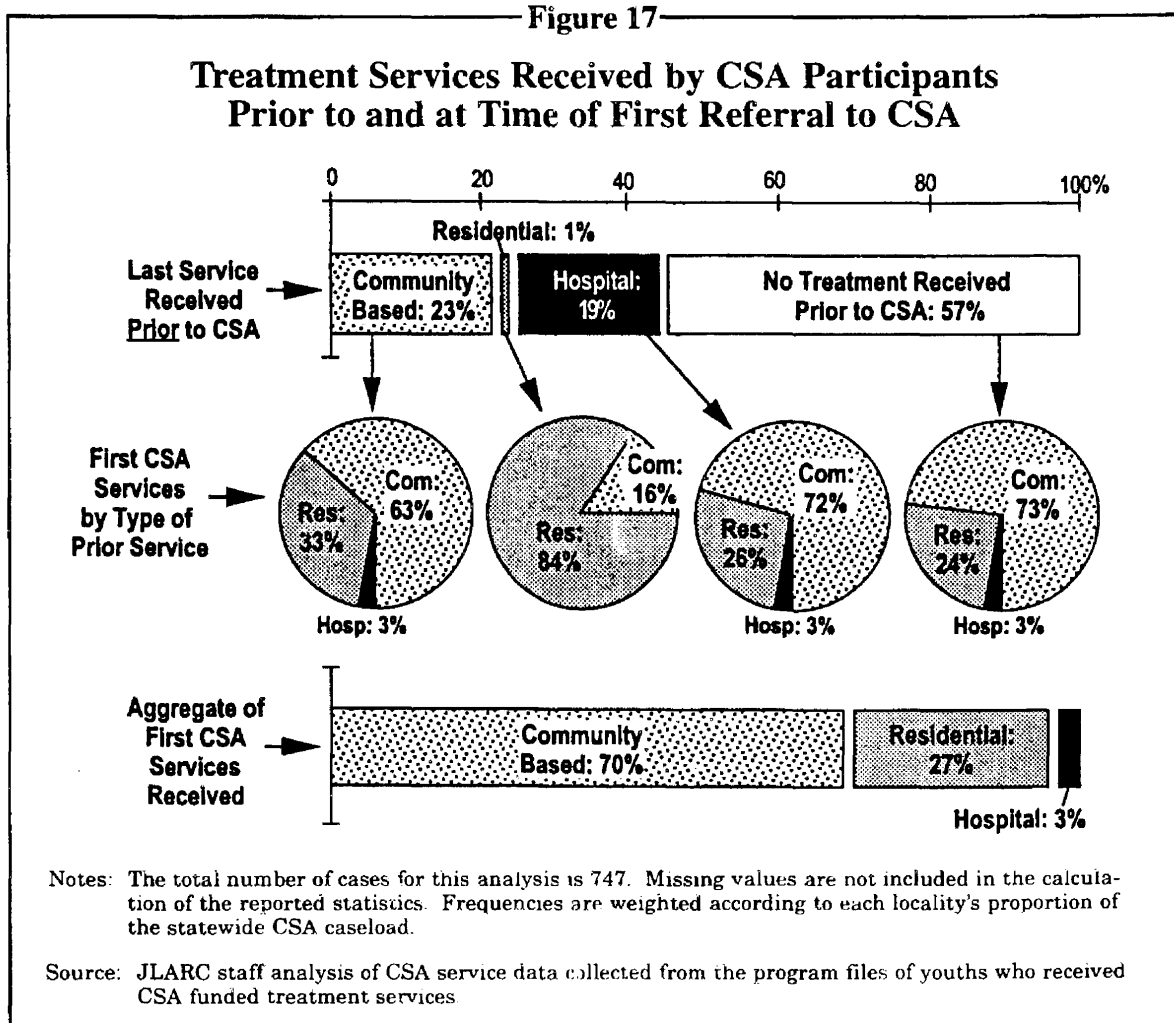
Because a youth in CSA can receive more than one service in a given year, the first step in this analysis was to develop a hierarchy of services from the least to the most restrictive. As shown in Exhibit 3, as a part of this strategy, each service that a youth received while in CSA was placed into one of three categories: (1) "least restrictive, community-based setting"; (2) "somewhat restrictive residential setting"; and (3) "most restrictive hospital or acute setting." Using this strategy, it was possible to examine changes in the treatment settings that may have occurred for youths who received multiple services at different points in time through CSA.

Exhibit 3

| CSA Funded Treatment Services Ranked from the Least to the Most Restrictive | | |
|--|---|----------------------|
| Treatment Category | Service Description | Category Rank |
| Least Restrictive Community-Based Services | All community-based services such as outpatient counseling, home-based care, day treatment services, day schools, and early prevention programs for parents and children. Also included are independent living skills, substance abuse counseling, and specialized foster care. | 1 |
| Somewhat Restrictive Residential Services | All services provided in a public or private facility where 24-hour care and supervision is provided. This includes institutional foster care and on-site 24-hour residential school programs | 2 |
| Most Restrictive Acute Hospital Services | Any residential-based hospital program designed to treat psychiatric disorders. | 3 |
| Source: JLARC staff analysis. | | |

Comparing Initial CSA Service to Prior Service. As it was anticipated that many of the youth in CSA might have received mental health related services prior to their admission to CSA, JLARC staff first compared the treatment services that the sample youths received prior to and at the time of their first referral to the program. The results of this analysis are reported in Figure 17.

As shown by the top bar on the graphic, prior to their first referral to CSA, approximately 57 percent of the sample had never received any type of treatment service. Of the remaining youths, 23 percent had received community-based care, and 19



percent had been hospitalized. One percent of the children in the sample had been in residential treatment as the last service they received prior to entering the CSA program.

In one sense, these figures run counter to many of the previously held notions about the at-risk children who come to CSA. It was generally assumed that most of the program's participants would have some history of institutionalization. The fact that almost six out of 10 children have no prior treatment history may be an indication that the localities are geared much more to at-risk prevention activities than originally assumed.

Once these youths were referred to the program, fully 70 percent were placed in a community-based initiative (bottom bar in Figure 17). While one would expect that a higher proportion of those children who had been in a residential home or hospital acute care unit would have received a similar placement under CSA, no clear pattern was observed. While the small proportion of children who were in residential programs prior to CSA were substantially more likely to be placed in a similar setting

by local staff, those from hospital acute care units were not. Consistent with the intent of CSA, there appeared to be a heavy emphasis on establishing community-based interventions, as from 63 to 73 percent of each group of children (excluding the small group of children who were already in a residential program) were placed in a community setting.

Comparing All Subsequent CSA Services to Initial Service. One method for determining whether local CSA staff are successful in either maintaining these youths in less restrictive environments (for those placed in the community at referral) or moving more children to the community (for those whose first service was in a residential or hospital acute unit) is to compare each child's subsequent placement made in CSA with their initial service. For each service change, a determination can then be made of whether the new service represented a move to a more restrictive environment, a less restrictive environment, or whether there was no change in treatment setting relative to the first referral.

In this type of analysis there are four trend lines that have meaning. The first is the line that represents the change in the proportion of children whose first CSA treatment setting was in the community. If this line remains relatively flat over the course of the sample youths' treatment history, this would indicate that the children who were placed in the community at the time of their first referral were typically maintained in that setting.

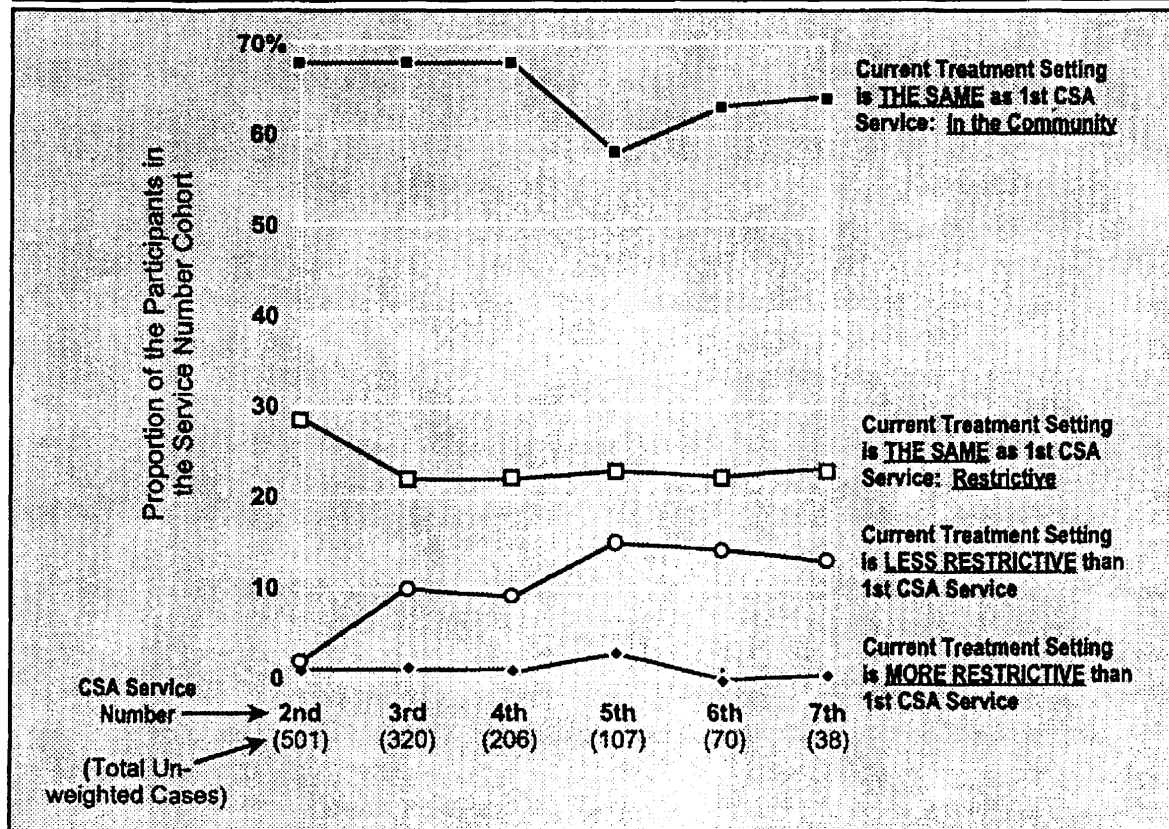
If this line shows a significant decrease, then the direction of one other trend line must be evaluated to assess the meaning of this decrease. This line represents the change in the proportion of youths who moved to a more restrictive environment when additional services were provided. Obviously, if the this line is increasing, then the thrust of services under CSA would have shifted in a direction that runs counter to statute.

Of the two other trend lines that were developed for this analysis, one reflects the change in the proportion of children whose first CSA setting was in more restrictive environment. If this line remains stable as youths receive additional services in the program, this would indicate that program staff are having trouble moving children out of their initial more restrictive placements and into the community. If this line shows a decline, there should be a corresponding increase in the fourth trend line used in this study: the proportion of children who were placed in less restrictive environments relative to their first placement. Figure 18 presents the results of this analysis. As is clearly shown, the line indicating changes that represent movement into a more restrictive setting is relatively flat as youths moved from one service to the next. Conversely, the rate of increase for those children who, relative to their first CSA placement, were moved into a less restrictive setting is substantially larger. This obviously reflects the movement of children from residential and acute care hospitals to the community.

Those children who were placed in the community when they first came to CSA and whose subsequent services represented no change from that type of place-

Figure 18

Changes in the Treatment Settings of CSA Participants as They Move Through Multiple Program Services



Note: The reported frequencies are weighted according to each locality's proportion of the statewide CSA caseload. The relative change in treatment setting for this graph was determined by comparing each new service to the first service the youths received at the time of their initial referral to CSA. Percentages may sum to more than 100% due to rounding.

Source: JLARC staff analysis of CSA service data collected from the files of youths who received treatment services.

ment are reflected in the top line on the graph. For the first four services received under CSA, the data indicate that these youths were, for the most part, maintained in a community setting. When these lines began to decrease (as CSA youths are moved from the fourth to their fifth service), there is a corresponding increase in the proportion of children who were moved to a more restrictive setting. However, this pattern reversed itself when CSA participants were moved into their sixth service.

The second line of this graph also illustrates that the difficulty CSA staff have with providing community-based treatment for a small portion of participants. Specifically, it appears that treatment in a more restrictive setting is consistently pursued for slightly less than a quarter of the children who receive services through the program. For these youths, it appears that their emotional and behavior problems are so severe and their adjustment to community-based treatment so poor, that program staff are unable to either place or maintain this group in the community. The following case

example illustrates the difficulty of serving some participants in a community setting. The subject of the case study is a young boy who, due to his biological mother's instability and drug use, was placed into the care of the Department of Social Services shortly after he was born.

When "John" was three years old, his natural father collapsed in his home and died of a heart attack. John was present when his father died and was discovered screaming while standing next to his father's dead body. His adoptive mother had three strokes that left her seriously disabled and unable to properly supervise and control John. During this time, John began to show signs of hyperactivity and began to demonstrate oppositional and defiant behavior in both the home and at school.

At school, he was tested and found to be mildly retarded and emotionally disturbed. At home, his mother's health problems limited her ability to properly supervise John. She responded to his behavior problems by physically abusing him — she beat him with her walking cane — and by allowing her older children to beat John as well. As a result of these beatings, John was removed from his mother's home and placed in an emergency shelter.

Since his first foster care placement, John had multiple placements through CSA, due mostly to his oppositional and noncompliant behavior. After being removed from his mother's home at the age of 12, John was placed in an emergency shelter. He ran away from this shelter and returned to his mother's house in March 1992. [As this locality was one of the pilot sites for CSA, services were available through the program prior to the passage of the Act in 1993.] While at his mother's home, John threw a knife at a friend and hit his mother in the chest. As a result of this behavior, he was placed at the Virginia Treatment Center for Children where he was treated with Imipramine for depression and impulsive behavior.

In April of 1992, he was placed in a foster home. During a six month stay at this foster home, John fought with his foster mother and her son, attacked a neighbor's child with a knife, and chased another neighbor's child with a meat cleaver.

After complaining that his foster mother hit him, John was transferred to a group home in October of 1992. During his stay at this facility, records indicate that John was demanding, hyperactive, and displayed sexually inappropriate behavior towards the female residents.

He was subsequently removed from the home and placed in a specialized foster care in the home of parents with a proven track record of success with troubled children. During his nine month stay at this

home, John destroyed furniture, cursed and abused his foster parents, went AWOL several times, stole a gun, stole a neighbor's bike, and urinated in the hallway of the house.

In November of 1993, the foster parents requested that he be removed from their care. The Department of Social Services moved John into another specialized foster care placement in another locality. While attending school in this locality, he assaulted a classmate. He also was caught choking one of the smaller children in the foster home. The parent of this home requested his removal.

In January of 1994, John was placed in another emergency shelter while other more permanent placement possibilities could be explored. During this time, his mother returned home and requested that he be returned to her. John was returned to his mother but disrupted this placement by staying out all night, getting suspended from school, cursing his mother, and threatening her with a knife. He was removed from his mother's house in April of 1995 and returned to an emergency placement.

Shortly after returning to the emergency shelter, he went AWOL, fought another resident, and was subsequently transferred to the only residential group home that would take him. In July, 1995, he ran from this facility to visit his sick mother. When the emergency shelter refused to take him back, he was transferred by the Department of Social Services to another shelter.

Shortly after arriving at this facility, he went AWOL and moved into a local housing project with an adult female from whom he contracted a venereal disease.

Since that time, he has been placed in three other foster homes and has had several AWOL incidents. His current foster care placement is considered temporary until the Department of Social Services can find a more restrictive placement with psychiatric services and a private day school that will accept John. If these placements are not located, John will be placed in detention because he is considered such a high risk.

Local program staff can more successfully pursue the goals of the CSA when working with children whose treatment needs are better addressed through the shorter-term community-based programs. However, for children such as "John" with chronic problems, necessitating longer-term institutional treatment, the less expensive treatment alternatives may simply be impractical.

The Cost of Treatment for a Cohort of Children in CSA. If localities have been able to successfully implement the community-based model of treatment for youths

in CSA, there is an expectation that the cost of the program for any given cohort of youth should diminish over time. This can occur in a number of ways. Significant cost reductions are possible when youths who are initially placed in high cost residential services are gradually moved into community-based programs.

Cost reductions might also occur over time for youths who receive community-based services. If these programs are successful in treating the behavior problems of this population, the intensity and associated cost of these interventions can be gradually reduced until the child is discharged from the program.

JLARC staff examined the total cost of treatment (excluding foster care maintenance payments) for those who were referred for services in FY 1995. Because the children in the sample entered CSA at different points in time during these fiscal years, the total cost that a child incurred over a 12-month period was divided by the total number of days in which they were eligible to receive care in that year. This period of eligibility thus represented the number of days between the date the child first received services, and the end of the relevant fiscal year. Because there was such a wide range between the largest and smallest CSA expenditures, the median participant cost was used to mitigate the effect of the extreme values in the data.

Despite the reductions that have been observed in the service levels for children who entered CSA in 1995, the cost of serving the youths has increased (top half of Figure 19). In their first year of service, the per day median cost observed for these children was \$25. By FY 1997, these costs had reached \$38 per day – an increase of 52 percent.

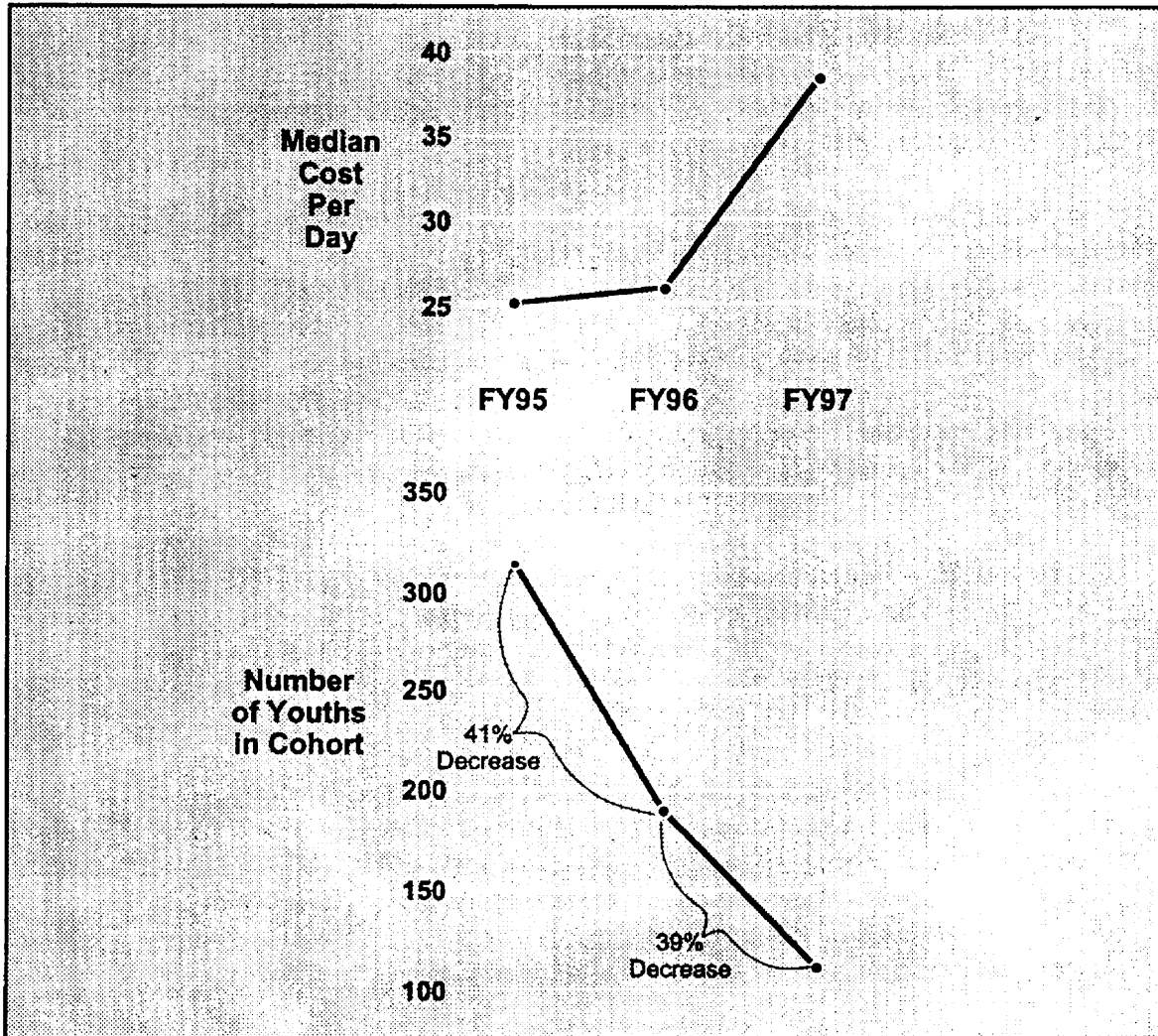
There appear to be two primary reasons for the observed cost trend. The first concerns the attrition rates observed for the children who came into CSA in FY 1995. As the bottom half of Figure 19 reveals, a large number of the children in each cohort leave the CSA program after one year. For example, from FY 1995 to FY 1996, 41 percent of the children left the program prior to the start of the next fiscal year. One year later, another 39 percent of these children were out of the program.

Except for those children who are terminated from the program for non-compliance, many of those who leave CSA within a year do so because they have successfully completed the program. Those who continue in treatment typically do so because they have emotional and behavior problems that have not been remediated. For a significant number of these children, the service plans will include longer periods of the more expensive services. As an example of this, the data collected for this study indicated that only 29 percent of the cohort of children who entered CSA in FY 1995 received services in each of the subsequent follow-up years. However, this group accounted for more than 70 percent of the cost of treatment for the entire cohort.

The second and perhaps more important reason from a policy perspective relates to the cost of care that localities face under CSA. In CSA's predecessor system, the rates that providers charged both the State and localities for treatment services

Figure 19

Trends in CSA Costs and Program Attrition for Children Who Entered CSA in FY 1995



Notes: Missing values are not included in the calculation of cost per day. The analysis of cases for youth entering CSA in FY 1995 was based on 316 cases. The cohort of youth in this sample who entered CSA in FY 1994 only represents those from this CSA population who did not leave the program in that year. As those who remain are more likely to have higher cost, this group was excluded from the cost analysis so as not to bias the study results

Source: JLARC staff analysis of cost data collected from the files of CSA participants.

were capped through a rate-setting system. When CSA was passed, the rate-setting program was eliminated.

Since that time, some local officials contend that the most significant factor influencing the cost of CSA has been a rapid increase in the rates that providers are now free to charge for their services. Others point out that the actual rates have not

increased, but providers are now separately billing localities for services that used to be provided as a package under the rate setting system.

According to the Virginia Coalition of Private Providers, it is the dysfunction of the child and not rate increases which have raised the cost of care. Because of higher levels of dysfunction, children in CSA today are more expensive to treat than those who were served five years ago.

JLARC staff examined this issue by analyzing CSA cost data for two cohorts of youths within three treatment settings. For children who entered CSA in FY 1995 and received CSA-funded treatment in later years, the data reveal substantial increases for the services provided in both the community and residential settings (Figure 20). Specifically, in FY 1995, the median daily cost of community-based care was \$32 per day. Two years later, these costs had increased by 53 percent to \$49 per day.

The cost of care for residential treatment was \$112 per day in FY 1995 for the cohort of children who entered treatment in that year. By FY 1997, localities were typically spending \$178 for each day of treatment provided in this setting to the same cohort of youth. This represents an increase of 59 percent. The rates observed for hospital acute care appear to have dropped, then stabilized at approximately \$236 per day. However, because the number of children in the cohort who received this type of care was small, these results for acute hospital care may be unreliable.

For children who first entered CSA in FY 1994 and received CSA-funded services in later years, the cost increases for residential care are substantial. Specifically, in FY 1994, the cost per day of care in a residential facility was \$90 per day. Three years later, the cost of care for this same cohort of youth had increased to \$207 per day -- an increase of approximately 132 percent.

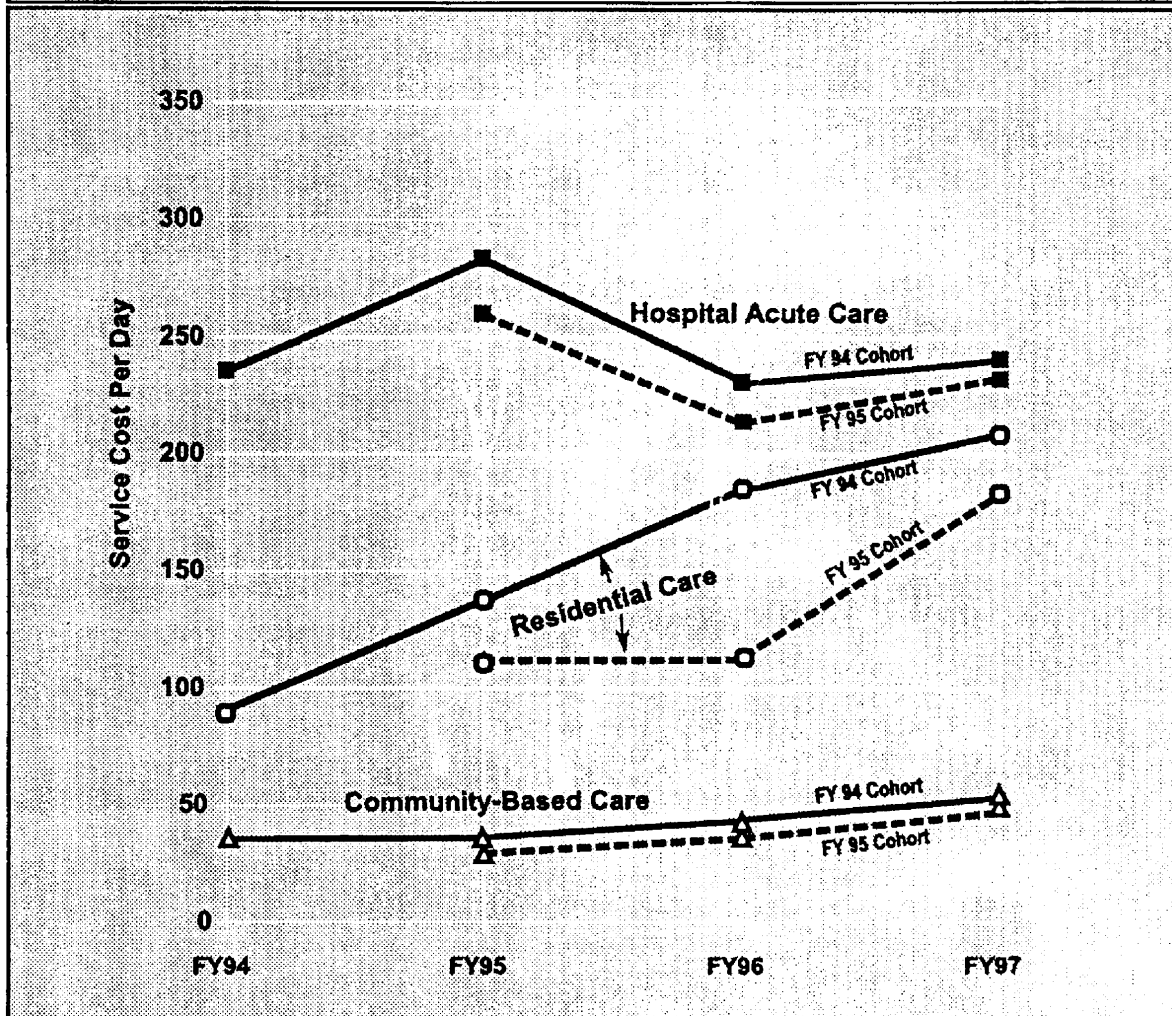
Thus, it appears that cost rates for residential and community-based care are components of CSA that local governments may be able to address to generate overall cost savings for the program. As has been documented in Chapter III of this report, most local governments that were surveyed statewide for this study indicate that they do not negotiate rates with providers. Rather than rely on a return to the rate setting approach of the old system, local governments should re-examine the approaches they use when establishing contracts for services with private providers.

CSA PARTICIPANT OUTCOMES

Although the implicit purpose of CSA is to provide at-risk youths with the treatment they need to improve their behavior, there is a limited statutory reference to the expected outcomes for its participants. As a result, there is some disagreement on how this aspect of the program should be assessed. For some, the litmus test of how well CSA is working is the degree to which its participants are being treated in a community-based setting. Those who hold this view point to the *Code of Virginia's*

Figure 20

CSA Cost Trends, by Type of Treatment Setting and by Year Youths Entered Services



Notes: Missing values not included in calculation of reported statistics. Cost figure was determined by dividing the total cost for the treatment setting by the number of days the services was provided. Results reported for "Hospital Acute Care" may be unreliable in some years as they are based on a small number of cases.

Source: JLARC staff analysis of data collected from program files of youths who received CSA services.

consistent emphasis on the importance of serving CSA youths in the community as further evidence to support this outcome as the sole standard for program success.

Others take issue with this view. These persons point out that the objective of CSA for its participants is clear – help the children eliminate or significantly reduce the negative behaviors that first brought them to the program. To these individuals, an evaluation of the success of CSA should address a straightforward question: Have CSA

participants successfully adjusted to the community by either eliminating or significantly reducing their negative behaviors?

In this study, an attempt was made to evaluate the adjustment that CSA participants appear to be making in school, at home, and in the community since receiving CSA services. This analysis is based on telephone survey data that was collected by the Virginia Commonwealth University (VCU) survey research laboratory, and through a review of juvenile and adult criminal records data.

The results from the survey indicate the behavior problems which are characteristic of many of the youths in this study have moderated. Overall, the children appear to be causing fewer problems at home, in school, and in the community. The post-CSA adjustment was less favorable for those youths who were officially diagnosed with specific emotional or behavior problems prior to CSA. Since receiving CSA services, these children were slightly more likely to be involved in physical fights, use cursing and abusive language, stay out late, ignore home rules, and runaway from home. However, the frequency with which these incidents were reported to occur were minimal.

Finally, and perhaps most encouraging, an estimated 70 percent of the parents or guardians that were surveyed stated that the services offered through CSA have helped to improve their child's behavior. These responses were consistently favorable, even after accounting for the level of risk that the child brought to the program.

Adjustment of CSA Participants in Home, Community, and at School Has Been Favorable

Although there are no specified participant outcome measures for CSA, there are inherent problems with focusing solely on the placement level as a measure of program success. Most notably, when placement changes are considered without respect to symptoms, there is a risk that the care of the child will be sacrificed merely to meet a program objective of treatment in the less intensive setting. While it is not the objective of this report to quantify performance measures for CSA, including some assessment of the behavior of this population is a necessary component of the evaluation of this program.

As noted earlier in this chapter, the VCU survey research laboratory contacted the parents and guardians of 200 children who received CSA funded treatment services in FY 1995. As a part of the survey, these respondents were asked to comment on the behavior of their child both before and after they received CSA services. The behaviors on which they were asked to comment were selected because they are characteristics or symptoms of certain clinically diagnosed problems. For example, children who are physically assaultive can be diagnosed as suffering from conduct disorder. Children who stay out late and refuse to obey their parents may be diagnosed as oppositionally defiant. As JLARC staff collected data on the pre-CSA diagnosis for the

children whose parents or guardians were surveyed, it was possible to compare their reported post-CSA behaviors with the pre-program assessment data.

Post-CSA Behaviors. The figures in Table 27 indicate how these parents responded when asked to comment on whether their child exhibited certain behaviors after receiving CSA treatment. An initial review of these data suggest that many of the problems that the children brought to CSA were still present after they received treatment services. For example, 40 percent of the survey respondents indicated that their child had been in fights with other children; 28 percent of the respondents' children were still staying out late according to their guardians; 41 percent stated that the children have cursed and verbally abused them; and 67 percent stated that their children generally ignore their home rules. As expected, in most cases, these problems were reported at higher rates for those children who had clinically-diagnosed behavior problems before entering CSA.

However, when the parents were asked to comment on the frequency with which these problems occurred, as shown in Table 28 (page 112), they generally responded from once a year or no more than six to 12 times per year. While this does not minimize the seriousness of some of these problems, the infrequency with which they are reoccurring does suggest that the children's behavior may be stabilizing.

School Performance. A particular problem for this population is their behavior and performance in school. Many of these children have been suspended multiple times. Some have been expelled from the public school system. Some of those who are still in school — public or private — have poor attendance. As a result of these problems and various learning disabilities, these children are often performing four and five grade levels below their chronological age.

Given these problems, JLARC staff were especially interested in evaluating the behavior and school performance of this population since they first began receiving CSA-funded treatment services. Therefore, survey respondents were asked to comment on their child's post-CSA attendance record, behavior, and academic performance. In each of these areas, the respondents were also asked to compare and assess their performance in these areas relative to what they were at the time the child was referred to CSA. Table 29 (page 113) summarizes their responses.

As shown, a clear pattern emerges in the responses for each of the areas on which the respondents were surveyed. According to their parents and guardians, since receiving services, the majority of the children's school performance has either improved or stayed the same. For example, three quarters of those surveyed indicated that their children's attendance has stayed the same (42 percent) or improved (31 percent).

In response to the question concerning the children's behavior in school, 54 percent of the parents cited improvement, while 22 percent indicated that the behavior has stayed the same. Concerning grades, the responses indicated improvement in 51

Table 27

**Proportion of Children Who Reportedly Exhibited
Certain Behavior Problems After Receiving CSA Services,
Controlling for a Pre-CSA Diagnosis of Related Problems**

| Did Youth Exhibit Post CSA Behavior Problems | Total In Sample With Post CSA Problem (Percent) | Child Was Diagnosed With Problem Prior To CSA And Still Exhibited Problem (Percent) | Child Was Not Diagnosed With Problem Prior To CSA But Now Exhibited Problem (Percent) |
|---|--|--|--|
| *Youth used alcohol or drugs | 16 | 100 | 13 |
| *Youth involved in fights with other children | 40 | 52 | 48 |
| **Youth used cursing and abusive language | 41 | 59 | 41 |
| Youth physically abused guardian or other adults | 14 | 46 | 54 |
| Youth stayed out late | 28 | 55 | 45 |
| **Youth ignored home rules | 67 | 55 | 45 |
| *Youth ran away from home | 15 | 41 | 58 |

Notes: A total of 200 respondents were surveyed for this study. The reported frequencies are weighted according to each locality's proportion of the statewide CSA caseload. Missing values are not included in the calculation of statistics. *Indicates the observed relationship was statistically significant at a .01 level of significance. **Indicates the observed relationship was statistically significant at a .10 level of significance. Because some cells have less than the expected number of frequencies, the chi-square statistic may not be a valid test in these cases.

Source: JLARC staff analysis of survey of the parents or guardians of the CSA participants. Survey administered by the Virginia Commonwealth University Survey Research Laboratory

percent of the cases. Approximately 24 percent of the parents stated that their child's behavior in this area was unchanged.

When compared to the responses concerning the children's pre-CSA performance, most of the children whose parents described their school behavior, grades, and attendance prior to CSA as "good," indicated that these youths have been able to sustain this performance since receiving services. Only for a small proportion of the cases did the parents and guardians indicate that the behaviors of their children had worsened. This typically occurred approximately 20 percent of the time for children whose pre-CSA performance in the relative areas was described as "good."

Table 28

**Frequency With Which Children Committed
Certain Behavior Problems After Receiving CSA Services**

| Did Youth Exhibit Post CSA Behavior Problems? | Once A Week (Percent) | Once A Month (Percent) | 7-12 Times A Year (Percent) | 3-6 Times A Year (Percent) | Once A Year (Percent) | Don't Know/ Did Not Answer (Percent) |
|--|--------------------------------------|---------------------------------------|--|---|--------------------------------------|---|
| Youth used alcohol or drugs | 2 | 8 | 22 | 12 | 16 | 40 |
| Youth involved in fights with other children | 2 | 6 | 18 | 31 | 36 | 7 |
| Youth used cursing and abusive language | — | 1 | 18 | 27 | 53 | 1 |
| Youth physically abused guardian or other adults | 3 | 2 | 46 | 38 | 6 | 5 |
| Youth stayed out late | — | — | 23 | 1 | 64 | 12 |
| Youth ignored home rules | 1 | 6 | 18 | 13 | 61 | 1 |
| Youth ran away from home | — | 11 | 4 | 33 | 4 | 48 |

Notes: A total of 200 respondents were surveyed for this study. The reported frequencies are weighted according to each locality's proportion of the statewide CSA caseload.

Source: JLARC staff analysis of survey of the parents or guardians of the CSA participants. Survey administered by the Virginia Commonwealth University Survey Research Laboratory

Juvenile Criminal Records. The final aspect of this analysis of participant outcomes concerns the youths' criminal records. Using survey data from the State Police, juvenile courts, and the Department of Corrections, the pre- and post-CSA criminal records of the youths in the complete JLARC study sample were analyzed. This analysis was designed to address two basic questions: (1) do youths who receive CSA services commit crimes following the receipt of these services? (2) if so, does it appear that the criminal behavior of these youths escalates from status offenses or misdemeanor crimes to more serious felonies?

A review of the criminal databases revealed that only a small portion of youths had been convicted of a criminal offense either before or since receiving CSA services. Specifically, only 14 percent of the youths in CSA had been convicted of an offense at the time they were referred to CSA. In the period following their participation in CSA, the arrest and conviction rate for this population remained the same as the pre-CSA rate of 14.

Table 29

**Parent or Guardian Perceptions of
CSA Participants' School Performance**

| Perceptions of Respondents Pre-CSA School Performance | Improved (Percent) | Got Worse (Percent) | Stayed Same (Percent) | Don't Know (Percent) |
|--|---------------------------|----------------------------|------------------------------|-----------------------------|
| Pre-CSA School Attendance | | | | |
| Good | 15 | 24 | 61 | 0 |
| Fair | 45 | 9 | 36 | 10 |
| Poor | 48 | 22 | 15 | 15 |
| Total Column Percentage | 31 | 19 | 42 | 8 |
| Pre-CSA Grades | | | | |
| Good | 30 | 27 | 42 | 1 |
| Fair | 55 | 3 | 38 | 4 |
| Poor | 61 | 11 | 15 | 14 |
| Total Column Percentage | 51 | 12 | 24 | 13 |
| Pre-CSA School Behavior | | | | |
| Good | 28 | 25 | 46 | 1 |
| Fair | 41 | 27 | 27 | 5 |
| Poor | 71 | 10 | 12 | 7 |
| Total Column Percentage | 54 | 17 | 22 | 7 |

Notes: A total of 200 respondents were surveyed for this study. Missing values are not included in the calculation of statistics. Reported relationships are statistically significant at a .01 level of significance using a chi-square test.

Source: JLARC staff analysis of survey of the parents or guardians of the CSA participants. Survey administered by the Virginia Commonwealth University Survey Research Laboratory.

Table 30 summarizes the criminal records that were identified for this population. The most significant finding is presented in the first row of the Table. What this reveals is that of the youths who had no criminal record prior to CSA (86 percent of the sample), only 14 percent were convicted of an offense after receiving treatment. Most of these offenses were misdemeanors (eight percent). Thus it appears that these children largely avoided the criminal justice system following their participation in CSA.

General Conclusions about CSA by Parents and Guardians. In light of these findings, it is not surprising that 69 percent of the parents who responded to the survey either agreed or strongly agreed with the statement that they felt involved in the CSA service planning process. Almost three-quarters indicated that the services which their child received were appropriate given the problems that needed attention. After accounting for whether the child was considered appropriately placed (using the

Table 30

Pre- and Post-CSA Criminal Behavior of Juveniles in JLARC Study Sample

| <i>Juvenile Criminal Record Prior To Receiving CSA Services</i> | | <i>Percent of Youth, Based on the Nature of the Crime Committed Since Receiving Services</i> | | | | |
|---|--------------------------|--|------------------------------|-----------------------|---------------------|----------------------------------|
| Most Serious Crime Committed | Percent of Youths | No Post-CSA Crimes | Felony Against Person | Other Felonies | Misdemeanors | Status and Other Offenses |
| No Criminal Record | 86 | 86 | 1 | 3 | 8 | 2 |
| Felony Against Person | 4 | 46 | 18 | 9 | 20 | 7 |
| Other Felonies | 3 | 12 | 21 | 24 | 40 | 3 |
| Misdemeanors | 5 | 56 | 0 | 9 | 23 | 12 |
| Status and Other Offenses | 2 | 63 | 0 | 4 | 20 | 12 |

Note: Reported relationships are statistically significant at a .01 level of significance. However, because 64 percent of the cells have counts less than five, chi-square may not be a valid test. A total of 747 cases were examined for criminal records data.

Source: JLARC staff analysis of data collected from CSA participant files

risk instrument and guidelines discussed in previous chapters), there was no appreciable change in the responses of the parents.

Finally, it appears that approximately 70 percent of the parents felt that the services provided through CSA helped to improve their child's behavior. Further, parents whose children were considered to be an acute or recent risk at the time they were referred to CSA were slightly more likely (52 percent) to indicate that the program had help to improve their children's behavior than those whose children were considered to have no risk or only a history of risk (47 percent).

The Need for Performance Standards Under CSA

If the services delivered through CSA are to be improved, the development of performance measures which can be used to evaluate the success of the program are essential. Relying only on the references in statute to the goal of service in the least restrictive environment does not provide a sufficient foundation to guide the development of performance or outcome measures for this system. As noted earlier, by focus-

ing solely on the level of placement, local CSA staff would be encouraged to make decisions about the appropriate treatment setting for seriously troubled children without respect to their actual symptoms. As these decisions (whether to move a child into the community) are likely to be primarily driven by cost, there is no assurance that quality of care can be sustained under CSA.

At the same time, if performance measures are pursued without respect to level of care considerations, a substantial number of children might receive excess services based on their risk and other behaviors. While this may result in a higher, more intensive level of care, it might also prove inefficient if the child's risk level indicated that he or she could have been served in the community.

Linking Program and Participant Outcomes. One local treatment specialist states that this problem can be addressed through the development of outcome measures that identify the placement to be achieved as well as the symptoms of the child which are to be remediated. This treatment specialist offered the following comments to illustrate how such a system would work:

An individual may be placed out of his family home in a residential treatment center because he exhibits aggression at a level of intensity that can not be managed in the home. Meaningful outcomes for this individual would be 1) a successful return to the family, and 2) a reduction in the intensity of aggression. Services are then selected to achieve these outcomes with providers understanding that a reduction in aggression within the residential group home is a successful outcome but not sufficient. The aggression must be manageable in the home.

With outcomes that jointly reflect both placement goals and participant behavioral objectives, localities would then have a meaningful tool to assess whether providers are producing the type of results required given the nature of the children they receive. The adoption of a statewide uniform risk assessment instrument (with level of care guidelines), as recommended in Chapter III, is the first step the State Executive Council needs to take to establish performance criteria for this system. Exhibit 4 provides a few examples of performance measures that might help increase the accountability of the CSA program.

Once the performance measurement system is in place and uniformly implemented across the State, both local governments and the State Executive Council would have the data needed to answer the following types of questions:

1. What were the risk levels of the children served by the locality in the past fiscal year?
2. What placement levels were suggested by the guidelines for this population, and what proportion of the times were those guidelines followed when making the service placement?

Exhibit 4

Possible Performance Measures for Local CSA Programs

- Proportion of CSA youth served with recent or acute risk
- Proportion of CSA youth served who were provided treatment services through the multi-agency planning process
- Proportion of youth who were placed in the treatment setting suggested by a uniform assessment instrument
- Proportion of CSA youth in residential programs or acute care hospital units who were moved into community-based programs

Source: JLARC staff.

3. What were the goals for service for the individuals who were placed in treatment in the locality in the past fiscal year?
4. To what degree were the goals obtained by the local service provider?

***Recommendation (8).* The State Executive Council should form a work group to identify the data needs and reporting requirements for a system of performance standards for CSA. This work group should establish the basic parameters of the performance assessment system that would be used statewide to evaluate local decisions regarding levels of care and participant outcomes.**

VI. State-Level Management of CSA

When changes to the categorical funding system for at-risk youth were being considered by the General Assembly in 1992, one of the main goals of the legislature was to develop a system for providing services to at-risk youth which minimized the oversight role of the State. Accordingly, the legislation establishing the State structure for CSA organized the leadership of the program with a council of State officials rather than a single agency, formed a State management team to provide technical assistance and training, and gave many of the program oversight responsibilities to local officials.

The CSA concept is unique. CSA has attempted to provide flexibility and allow for creativity in addressing a complex problem. A State and local partnership exists and needs to be maintained. There is a need to build upon these strengths that are offered by the general approach. While there is no reason to question the decision to grant localities the flexibility needed to develop service plans for at-risk children, there are concerns, however, that the model of State oversight envisioned for CSA is not adequate for a \$150 million program.

During the first four years of the program, a considerable amount of criticism has been leveled at both the structure of the program and the actors responsible for the State-level management of CSA. According to a number of State and local officials, the structure for CSA has divided leadership for the program across too many agencies while leaving important questions concerning program accountability and oversight to an uninterested State Council, a disorganized management team, and an understaffed agency.

In this chapter, JLARC staff assess the State-level management of CSA by focusing on the effectiveness of the current structure in organizing the program oversight, technical assistance, and policy development activities for CSA. In addition, the issue of whether changes should be made to the program at the State-level is also discussed.

The findings from this review indicate that the program oversight demands created by the size and nature of CSA cannot be adequately addressed at the State level within the framework of the current management structure. Due in part to the emphasis placed by CSA on shared management responsibilities, a vacuum has developed in the State-level oversight of the program, leaving critical gaps in the State's management, oversight, and policy development activities for CSA. Implementation of policies that have been initiated to address perceived problems with the program have been slowed by confusion, lack of communication, and a waning interest in CSA on the part of key actors at the State level.

Given the rate at which CSA is growing and the associated fiscal implications, significant changes are needed in the organization of this program at the State level. These changes, which include reorganizing the State Executive Council, realigning the Office of Comprehensive Services, streamlining the two-tiered management structure,

and strengthening the capacity of the Office of Comprehensive Services to conduct appropriate oversight, have the potential to substantially improve the local operation of CSA.

Additionally, and in conjunction with basic structural changes to the system, State officials should be encouraged to more actively pursue the use of Medicaid funds to offset the costs of CSA to both the State and local governments. Based on an analysis conducted by JLARC staff, it is estimated that about \$40 million of CSA annual costs could be paid for entirely with federal dollars by more closely linking CSA with the State's Medicaid program.

PROBLEMS WITH CSA'S STATE-LEVEL MANAGEMENT AND STRUCTURE

One of the reasons that CSA was considered such a unique program when it was created over five years ago relates directly to the State management structure that the General Assembly established for the program. Unlike the traditional oversight model in State government in which a single agency is vested with the policy development, management, and oversight responsibilities for locally implemented programs, the State-level structure is predicated on the concept of inter-agency cooperation and local control.

Accordingly, through a legislatively mandated two-tiered management structure, the CSA State Executive Council was established to direct the program oversight and policy development activities of the program, while receiving policy advice from a State Management Team, and staff support of the Office of Comprehensive Services. Reportedly, because of the strong role envisioned for local governments under CSA, the Council has promulgated few standards. Nor has the Council directed the Office of Comprehensive Services to put oversight controls in place. Although this structure was intended to promote collaboration and creative policymaking among the State agencies on the Council, it has not had these desired outcomes.

Perhaps because no one agency is responsible for CSA, the interest of the agency directors who serve on the Council appears to have waned over time. This has slowed progress on the policy work needed to establish a program of utilization review for CSA, as well as proposals for alternative funding sources to provide relief to local governments for the growing costs of CSA. In addition to these problems, persistent disputes, poor communication, and confusion about the roles between the Council, its management team, and the Office of Comprehensive Services have worked against this non-traditional approach to State oversight. Moreover, the quality of the support which the Council needs from the Office of Comprehensive Services has been seriously hampered by the agency's lack of staff.

Partially as a result of these problems, the most basic elements of an effective management structure — consistent oversight, role clarity among key entities, strong

policy guidance, and quality technical assistance — are usually absent from the CSA State management structure. Not coincidentally, the State has no effective way to ensure the proper accounting of funds or conduct useful reporting on the children who are served through CSA. Additionally, State technical assistance and guidance to localities in interpreting aspects of the State statute is provided non-systematically and is sometimes in error.

CSA State Structure Has Impeded the Effective Management of CSA

Unlike the local CSA structure, where the main purpose is to provide appropriate services for at-risk youths in their communities, the State's primary role is to provide the funding to ensure that the CSA works effectively statewide, and to put the necessary policies in place to protect the integrity of the program's resources. Given this, it is important that the State structure possess three characteristics that are essential to its effective management of the program: (1) role clarity among State actors, (2) consistent policy guidance, and (3) strong oversight responsibilities. If these factors are not present, the State does not have the tools to efficiently carry out its duties for CSA.

As noted in Chapter I, the State Executive Council — CSA's governing body — is responsible for establishing programmatic and fiscal policies, overseeing the distribution and use of CSA funds, and coordinating the support work needed from each agency represented on the Council. The State Management Team is appointed by and reports to the Council. This entity is responsible for developing policy recommendations to improve the operation of CSA and for providing technical assistance and training to localities.

Accountability Problems with the Council. CSA was created on the premise that a shared agency approach to the program would foster creative collaboration. In keeping with this philosophy, the State Executive Council was formed with the directors of six agencies as its core membership. However, there have been problems with this structure. Because no one agency is responsible for CSA, none of the directors on the Council has shown a willingness to take the lead in conducting the business of CSA.

An initial indication of this concern are the attendance rates for agency directors who serve on the Council. The *Code of Virginia* places the authority to approve CSA policies with the State Executive Council with the expectation that the agency directors will provide proactive feedback, dialogue, and collaboration in assessing program initiatives. As Table 31 shows, the attendance rates of several agency heads have dropped over the years, suggesting that the directors' dedication to CSA has decreased since the program was established. While alternates did sit in for the missing agency directors in most cases, the absence of the agency heads themselves suggests a lack of top leadership interest and guidance for a program which relies heavily on inter-agency input and cooperation.

Table 31

Attendance Rate of Agency Heads at State Executive Council Meetings

| Agency | CY 1993 | CY 1994 | CY 1995 | CY 1996 | CY 1997 | Total |
|---------------|---------|---------|---------|---------|---------|-------|
| DJJ | 100% | 76% | 33% | 25% | 40% | 55% |
| DMHMRSAS | 67% | 57% | 33% | 75% | 100% | 61% |
| DOE | 0% | 14% | 8% | 0% | 0% | 7% |
| DOH | 100% | 71% | 42% | 33% | 40% | 57% |
| DSS | 100% | 95% | 83% | 8% | 0% | 66% |
| Supreme Court | 83% | 71% | 25% | 92% | 60% | 66% |

Note: The first State Executive Council meeting was held in September 1993. The last meeting accounted for in this table was May 1997. (Number of meetings: CY 1993=6; CY 1994=21; CY 1995=12; CY 1996=12; CY 1997=5)

Source: JLARC staff analysis of State Executive Council Minutes

As a result of the declining interest of the agency heads, little attention has been given to the problems which plague this non-traditional approach to State management. These include inadequate resources, poor reporting and monitoring mechanisms, and minimal controls for the program.

Inadequate State-Level Oversight and Monitoring of CSA. According to § 2.1-746 of the *Code of Virginia*, the State Executive Council is responsible for overseeing “the administration of state interagency policies governing the use, distribution and monitoring of moneys in the state pool of funds and the state trust fund.” As its administrative arm, the Office of Comprehensive Services conducts the day-to-day fiscal operations for the Council such as general budgeting procedures for the program as well as reviews of supplemental funding requests, pool reimbursement requests, and quarterly utilization reports from the localities. In addition, the Office of Comprehensive Services is the primary point of information and technical assistance for CSA.

However, while it prescribes the makeup and duties of the Council, the *Code of Virginia* is silent on the expected and appropriate duties of this Office. This omission was most likely a conscious decision by the legislature to avoid the creation of the traditional State agency/local government oversight relationship. This action reflects the difficult task of achieving a balance between the proper level of State oversight and local flexibility and control.

Although this new approach to State oversight was meant to create a structure of management that relies on more accountability and self-monitoring at the local level, the absence of any statutory authority has left the Office of Comprehensive Services without the authority to establish some of the basic elements of program oversight to ensure the integrity of the CSA dollar. While the Office has implemented some compliance and monitoring initiatives (such as revising quarterly reporting requirements and the supplemental allocation request process), it appears that this failure to

provide adequate oversight results mainly from three existing conditions of the CSA State system:

1. the lack of clearly defined statutory responsibilities at the State-level which has caused role confusion among State actors;
2. an inadequate number of staff at the Office of Comprehensive Services to complete these functions; and
3. poor management and accountability of administrative responsibilities.

For much of the program's history, there has been concern that inadequate attention has been given to the monitoring of CSA fund expenditures. JLARC staff interviews with former and present Office staff indicate that problems did exist regarding the ability of the Office to achieve an effective system of fund monitoring. They indicated that this was mainly due to the lack of staff for this effort as well as the lack of existing procedures or fiscal reporting requirements for this relatively young program.

In addition, when the State-level management structure of CSA was created, the operational tasks of the Office of Comprehensive Services were assigned to staff in different agencies, in support of the notion of interagency cooperation. For example, the director of the Office was classified as a Department of Social Services position, the fiscal agent responsibilities of CSA were placed with the Department of Education, and the technical assistance staff person was classified as a position in the Department of Mental Health, Mental Retardation, and Substance Abuse Services. According to the present chair of the State Executive Council, this undermined attempts to put an effective reporting system in place due to the cumbersome operational structure of the Office's main functions.

In addition, it appears that there was a failure to institute an adequate system of basic management and administrative techniques when CSA was established. Consequently, little or no follow-up or review of local expenditure reports were conducted. Moreover, a lack of consistent reporting techniques led to inaccurate caseload counts for many of the localities. Since caseload numbers are used to calculate unit cost data, it appears that the accuracy of local unit cost estimates reported by the State are suspect.

For example, one locality reported to the Office that it had served 35 cases in CSA during FY 1995. The Office then estimated the locality's average unit cost as \$5,154. When reporting figures for FY 1995 to JLARC staff, however, the locality admitted that it had provided an inaccurate count to the State and that its actual caseload for FY 1995 was 15. This increased the locality's unit cost to \$12,026.

Moreover, the absence of uniform reporting criteria has caused inconsistencies in what some localities report as treatment costs to CSA. For example, Fairfax County, which has been criticized as having the highest CSA costs in the State, includes therapeutic foster care in its aggregate treatment cost totals. Many other locali-

ties do not. This has the potential to inflate the differences in unit cost between Fairfax County and localities in the rest of the State.

This lack of controls instituted at the State-level to ensure proper accounting of funds and effective procedures at the local level have slowed attempts to make localities accountable for their service and funding decisions. Until FY 1998, the "Pool Reimbursement Request/Quarterly Utilization Report" form designed by the Office did not require localities to designate how much of their CSA funding was used for specific types of services. Consequently, no data were collected on the types of residential services being provided by the locality, such as campus-based residential care, hospitalizations, or other types of residential group homes. Moreover, other types of services were not classified separately. As a result, no one in the State was able to determine what types of services CSA funds were actually paying for and whether some services were used more prevalently in some localities as compared to others.

In FY 1998, the office did modify the form to collect more specific fiscal data. However, the Office of Comprehensive Services currently does not have data that is child-specific or service-specific. Localities report aggregate data to the State that cannot be decomposed into participant data. As a result, the Office is significantly hindered in its ability to address basic policy questions about the program.

The Office is also impeded in its ability to conduct field monitoring of the program. When the CSA State structure was created, it was not envisioned that the Office would assume an aggressive role in monitoring the local practices of CSA operators. Consequently, few staff and almost no local operational standards were put in place. In fact, for the majority of the Office's existence, three staff were expected to address the program's State-level responsibilities in technical assistance, financial analysis, and administrative responsibilities. No role was created in the Office for compliance and monitoring functions.

As a result, the current State oversight structure does not have uniform program criteria and assessment procedures. Further, without the approval of the State Executive Council, the Office of Comprehensive Services cannot establish mandatory program criteria and assessment procedures. This absence of standards means that the State cannot assess local service and expenditure decisions using uniform measures. In the majority of localities, no mechanism is in place to ensure that placement decisions accurately reflect the actual risk of the child. Therefore, the Office's inability to monitor the field's service decisions clearly restricts its ability to ensure that State funds are expended in an appropriate manner.

Especially problematic is the Office of Comprehensive Services' inability to organize a solid database on the various local strategies that are being used to implement CSA. Without such a database, the agency has never fully addressed the localities' needs for reliable information on "best practices." Further, the absence of quality program implementation data has prevented the Office from proactively addressing local implementation problems that may unnecessarily increase the cost of CSA. For example:

In FY 1997, one locality submitted a supplemental funding request of \$2.7 million to the Office of Comprehensive Services. Reacting to the high dollar amount requested, the Office scrutinized the locality's administrative policies and found that the locality routinely did not include the multi-agency team in foster care residential case decisions, some of which cost nearly \$150,000 for the year. Due to the sum-sufficient nature of the additional service funding requested, the Office was statutorily required to approve the locality's supplemental request. The Office then instructed the multi-agency team to review all residential cases for the locality and take corrective action in its implementation policies.

Due to the absence of local implementation data, the Office was not aware of this locality's implementation problems until it reacted to the unusually high supplemental funding request by conducting further research into this specific jurisdiction's policies. If there had been a database which kept current information on local implementation practices, the Office could have identified any procedural problems on a routine basis and addressed them proactively. Instead, the Office currently plays a reactive role and, as with the above case example, often becomes aware of a problem after the improper policy has been in place for a substantial amount of time and funds have already been spent.

Additional actions should be taken in compiling more accurate information on local implementation and funding procedures. For example, in two localities visited by JLARC staff, internal auditors identified problems with the implementation of CSA in their jurisdictions. In one locality, the internal auditor found that crucial financial controls were knowingly ignored on a regular basis by agencies participating in CSA, that no one in the CSA local structure was held accountable for the financial reporting function, that accounting for CSA was maintained in only one agency's books, and that purchase orders were approved with incorrect rates and terms.

In addition, the locality's court service unit provided non-mandated placements which exceeded the locality's protected level for non-mandated funds. In response, staff from the court service unit and the Department of Social Services (which acts as the CSA fiscal agent in this locality) reclassified these court cases as mandated foster care prevention in order to receive supplemental funding from the State to cover the overspending for these costs.

These problems were never reported to the Office of Comprehensive Services. One way the agency could improve its oversight of local administrative and funding practices is to request and systematically review the results of all internal local audits which pertain to CSA.

The recent increase to seven staff at the agency (one of whom will be in charge of compliance) will better enable the Office to fulfill its administrative functions in a more comprehensive manner. Even with the addition of staff, however, the Office will

need to design a more structured mechanism for reviewing local funding expenditures and requests so that all local CSA programs are periodically examined.

Recommendation (9). The General Assembly may wish to amend the *Code of Virginia* to require that the State Executive Council develop data collection standards for a client specific database to be used by all localities. This database should include individual participant characteristics, service utilization and costs, and outcomes of youths served by CSA. This data should be collected at the local level and submitted periodically to the Office of Comprehensive Services.

Recommendation (10). The Office of Comprehensive Services should ensure that all statutory CSA requirements are met by a locality before granting supplemental funding.

Recommendation (11). The Office of Comprehensive Services should establish a systematic monitoring mechanism for assessing local funding and operation activities to ensure they are consistent with the requirements of State statute and the intent of CSA. The Office of Comprehensive Services should require localities to submit all local internal audit results which pertain to CSA.

State Guidance Under CSA. The need for clear guidance and technical assistance from State officials is evident in several areas of CSA. For both of these areas, ambiguities in the language authorizing CSA's State-level structure as well as lax or erroneous implementation efforts by State actors have created problems for the program. As the *Code of Virginia* does not outline a role for the Office of Comprehensive Services, problems have emerged in the relationship and responsibilities between this office, the State Management Team, and, in some cases, the State Executive Council. These problems have been perpetuated by poor communication between these entities which has substantially weakened the ability of the State to provide effective and accurate guidance to the localities on the interpretation of CSA statute and other technical assistance issues.

One example of this involves the eligibility category used for children who receive special education services. Under the current policy of the State Council, localities are allowed to classify special education services as mandated when they are provided services in either "private day facilities" or "public day facilities." However, the *Code of Virginia* does not authorize the categorization of public school special education services as mandated. It clearly states that special education services for *private* school educational programs must be paid for using mandated funds (§ 2.1-757). No mention is made of public day facilities/services. Therefore, CSA State officials' policy that certain public school services for special education children are mandated does not appear to be legal. Because the State is obligated to fund services for mandated children sum sufficiently, the fiscal implications of this problem are clear.

Although it is the statutory role of the State Executive Council to make such decisions, it appears that other entities actually set the policy. The State Management Team wrote in its report to the Council that a locality may decide that some of the services on the child's service plan are mandated if needed to keep the child out of a more restrictive placement for special education purposes. Therefore, the Management Team decided that children do not need to be in a private day or residential placement in order to be mandated.

The Director of the Office of Comprehensive Services obtained a letter from the Attorney General's office which commented that the conclusion of the Management Team report "appears consistent with State and Federal law." However, the letter then went on to state that a legal review of the issue seemed unnecessary at that time and consequently the letter did not constitute an official opinion. Using this letter as legal support for its policy, the Management Team constructed an information document, containing the new special education/mandated policy for use as a reference tool by localities when implementing CSA. The State Executive Council approved this document before it was disseminated to the local CSA field. As noted earlier, the Council supported this approach of allowing less costly and restrictive services within the public school environment if private school placement was otherwise imminent.

JLARC staff interviews with Management Team members, however, illustrate that this issue is far from clear-cut. A key Management Team participant in this policymaking process acknowledged that one of the main reasons this policy was put in place was to enable special education children to receive services that otherwise would be subject to non-mandated funding requests. The reasoning for this was that many localities do not set aside non-mandated funds and therefore these children would not be served if the "private/residential" criteria were strictly enforced.

This ignores the fact that the majority of children referred from the juvenile courts must go through the non-mandated funding approval process as well as other youths referred by the Department of Health and the Department of Mental Health, Mental Retardation, and Substance Abuse Services. It is not clear why an exception was made for the special education population.

The activities of the State Management Team on this issue and others can best be understood in light of the role it has played in helping to develop policy for the foundation of CSA during the early years of the program. Relative to agency heads, the Management Team members had more experience with the actual programs involved in CSA as well as more contact with the localities. Five members from local CSA management teams presently sit on the State Management Team with the purpose of providing insight into the local perspective of policy development.

Now that CSA is more established and has become operational, there is some question as to the role the State Management Team should play in this new environment. It does not appear that the current State-level structure has worked effectively

in utilizing the tools of the management team in conjunction with the Council and the Office of Comprehensive Services.

Problems with Technical Assistance. As Exhibit 5 illustrates, a number of functions need clarification in the State structure. Another major problem with the lack of role clarity between these entities relates to the provision of technical assistance to the localities. Due to State-level confusion regarding training responsibilities as well as poor communication and coordination in this effort, the provision of training to the localities has been inconsistent.

Although the Office of Comprehensive Services does not have statutory responsibilities for the provision of training, it plays a crucial role in the process since it is the administrative arm of the Council. This has led to tension and confusion between the Management Team and the Office of Comprehensive Services concerning which entity should take the lead on training. For example, the Office of Comprehensive Services recently formed a Training and Technical Assistance Steering Committee. This committee's mission is to address the training needs for the localities. However, there has been confusion expressed by the Management Team, which has its own training group, about the purpose of the committee. Communication and collaboration between these two training groups has not been adequate.

Exhibit 5

Functions in Need of Role Clarification

| Functions | Current Disputes Among State CSA Actors |
|---|--|
| Training and technical assistance to the localities | Why do two training work groups exist — one under the State Management Team and the other under the Office of Comprehensive Services? Functions in the past have been duplicative and uncertainty currently exists about their separate roles. |
| Creation and coordination of work groups | Who should be responsible for this — the State Executive Council, the State Management Team, or the Office of Comprehensive Services? |
| Policy development and recommendations | Who should be responsible for this — the State Executive Council, the State Management Team, or the Office of Comprehensive Services? |

Source: JLARC staff analysis of State Executive Council and State Management Team meetings, structured interviews, and JLARC survey data of CSA local multi-agency team chairs.

In addition, the State Management Team has poorly managed the activities of its own training and technical assistance work group. This work group was originally formed to address the team's responsibilities in this area. However, the Management Team has not provided adequate guidance to this work group, causing it to question its responsibilities, tasks, and timeline. In interviews with the training work group, members complained that the Management Team has not communicated its priorities to the work group and has been lax in assigning members, including a chairman. This has slowed much of the progress of the work group, which, without direction, has not contributed meaningfully to CSA training needs in the State.

More importantly, based on a JLARC survey of local governments, it appears that the training provided by these groups does not adequately meet the needs of local CSA staff. Survey responses indicated that there continues to be a demand and need by most localities for formalized group training on basic CSA policies, procedures, reporting techniques, and best practices regarding successful local implementation and technology initiatives. According to JLARC survey results, approximately 40 percent of localities responded that they were not satisfied with the guidance their localities have received from the State regarding the administration and funding of CSA. (The response rate for this survey was 89 percent.) Moreover, during JLARC staff interviews, several localities commented that the training provided by the State does not match the localities' actual training needs.

One local multi-agency team complained that they are "flying by the seat of their pants" in trying to understand where the system is supposed to be going and how to get there. Another locality commented that it sees a lot of other localities recreating the wheel because they are unaware of what is being practiced in other jurisdictions.

Besides the poor communication and organization between the entities handling the training for CSA, it appears that neither the Office of Comprehensive Services nor the State Management Team has adequate staff to support their training and technical assistance efforts. Even with the new positions being added to the office, there is only one position in the agency designated for training and technical assistance for CSA. Moreover, the Management Team, which is statutorily responsible for the provision of training and technical assistance to the localities, has no administrative staff to carry out this activity.

Due to this lack of staff, both the Office of Comprehensive Services and the State Management Team have worked with the Virginia Institute of Government (VIG) and the Virginia Institute for Social Services Training Activities (VISSTA) in creating training programs for the local multi-agency teams. Several regional training seminars have been offered to local CSA officials in the past, and more workshops are being planned. However, the lack of collaboration and communication between the Office and the Management Team has impeded the effective utilization of VISSTA and VIG's resources for CSA training opportunities.

Another problem area involves the creation and coordination of work groups. Currently, both the Office of Comprehensive Services and the State Management Team

have work groups to assess various policies and program initiatives. The State Management Team has four work groups: training and technical assistance, budget and funds development, prevention and early intervention, and program and services development. The Office of Comprehensive Services work groups have focused on training and technical assistance, assessment, and utilization management.

Members of both training and technical assistance work groups have expressed concern to JLARC staff that the efforts of these groups are duplicative. In addition, both the State Management Team and the Office of Comprehensive Services have work groups which have utilization management as a main part of their agenda.

Clearly, a more effective mechanism is needed in utilizing these work group members' time and resources. The responsibility of assigning work groups and their subsequent oversight should be clearly defined in order to ensure a less cumbersome and duplicative process. The last section of this chapter discusses JLARC staff proposals for changes in the current State structure of CSA.

State Policy Development Activities Have Lagged or Been Absent

The State faces several policy challenges in the management of CSA such as rising program costs, utilization review considerations, and the continual pressure to identify ways to ease the financial burden of CSA. As such, the need for proactive policy development is essential to the successful evolution and development of the program. Despite this, Council efforts in conducting policy assessments for CSA and developing proposals to guide the future direction of the program have been minimal.

While it has devoted a substantial amount of time to establishing a utilization management process for the program, the Council has neglected other policy development needs identified by the localities. JLARC staff interviews with local administrators of CSA suggest that there is a need for State policies regarding issues which localities cannot address on their own. Local CSA officials commented that the State can advocate needed changes in State policies and take a leadership role on statutory revisions. Using local and State input, JLARC staff identified three of the major policy issues which currently face the State for CSA: (1) utilization management, (2) the use of Medicaid funding for CSA services, and (3) the use of State beds for CSA purposes. What follows is JLARC staff's assessment of the State Executive Council's positions and performance in these areas.

Utilization Management. As noted in Chapter III, utilization management (UM) is a combination of two processes: (1) case management, which involves the identification of individual needs and the subsequent services received, and (2) utilization review, which evaluates how well the whole program is meeting its goals. Given that the CSA program as a whole involves a host of service and placement decisions which currently are not assessed or evaluated, it was the intent of the State Executive Council to construct a general approach to UM for all CSA services. Consequently, the Council contracted with a Virginia Commonwealth University (VCU) consultant in

June 1996 to develop a utilization management system plan that would be applicable to all aspects of CSA service provision.

In December 1996, the VCU contractor provided the Council with a feasibility study on whether UM could be beneficial to the CSA process. In July 1997, the contractor's draft utilization management instrument was presented to the Council for review. The Council is currently reviewing the draft and expects a final instrument to be ready by the fall of 1997. For the most part, the process for developing a UM policy for CSA has been protracted and, consequently, progress on this initiative has been slow. The Council has been discussing the establishment of utilization review in CSA for almost two years, yet a system is still not in place for local and State implementation.

In the past six months, however, the Council has pursued a UM policy more aggressively. For example, it formed a Utilization Management Steering Committee which has met regularly to discuss this issue and its operational needs. In addition, the Council has provided a video teleconference on public television to address local misconceptions about what is intended by UM under CSA. Future video teleconferences are planned. In JLARC interviews, Office of Comprehensive Services staff stated that it is making plans for future training in UM and that it is currently working on a workplan draft for UM training.

Quite apart from the issue of the process associated with developing a UM policy is the substance of the proposed policy. If this proposed policy is to have a significant impact on CSA, several changes will need to be made. Under the proposed policy, a locality is not required to use utilization management practices unless it requests supplemental CSA funding from the State. In this situation, the locality must show that UM was applied to all of its residential cases. There is no requirement that UM be used for any other CSA services. Moreover, in FY 1996, 65 percent of the localities in the State requested supplemental funding. Therefore, more than a third of the localities in the Commonwealth are currently under no obligation to adopt a utilization management process.

During the 1997 Session, the General Assembly adopted language in the Appropriations Act which directed the Department of Medical Assistance Services (DMAS) and its contractor to work in conjunction with the State Executive Council in designing a utilization review process for CSA cases in which youths received residential placements. This would provide localities that participate with a retrospective view on how well they review and assess CSA residential placements. The vendor would collect the relevant data from the locality, analyze it, and then provide non-binding recommendations on how the process can be improved. The DMAS report on its progress in this area is due on December 12, 1997 to the General Assembly.

Using the DMAS contractor's instrument would be a way that a locality could satisfy the requirement to demonstrate it has instituted effective cost control measures when applying for supplemental funding in CSA. However, localities can also choose to use their own UM procedures to meet this requirement. Currently, there is

no statutory provision for localities to use utilization management for CSA services provided (except for residential placements/supplemental funding discussed above).

Therefore, although the VCU study showed that UM in CSA would be beneficial as well as feasible, there is no current guarantee that local governments will be assessing the services and placements they have provided under CSA in a consistent manner. Further, the State Executive Council has not discussed putting together a legislative package to address these concerns. Given that the majority of CSA funding comes from the State, and given the benefits a UM process can provide, it would be beneficial for the General Assembly to require that localities have a utilization management program.

Moreover, since localities are not required to adopt the UM process designed by the Council and VCU, the Legislature may wish to recommend that all local UM plans contain the same basic principles and outcome measures as sanctioned by the State system. This would help ensure that each locality is applying UM in a consistent manner and that outcomes are assessed against a common standard. A recommendation pertaining to this issue is discussed in Chapter III.

The Link Between Medicaid and Mental Health Services. Medicaid is a joint federal and State program that finances health care for low-income Americans. Within broad federal guidelines, each state establishes its own eligibility standards, determines the type, amount, and duration of services to be provided, sets payment rates and administers its own program. To help defray the cost of the services funded through Medicaid, the federal government pays a portion of the program's total expenditures for each state. For Virginia, the federal government reimburses the State for 51.5 percent of the payments made under its program.

Medicaid is an important source of funding for the treatment of serious mental illness, both long-term and acute. As with all state Medicaid programs, certain services provided by Virginia's program are mandated by the federal government, while others are optional services that Virginia has elected to provide. Virginia's Medicaid State Plan provides a variety of inpatient and outpatient services for the mentally ill which can be provided to children by hospitals, physicians, psychologists, hospital outpatient departments, or Community Services Boards.

Most Virginia Medicaid funded psychiatric services, such as inpatient psychiatric care and counseling, are preauthorized by Medicaid and a fee for service is paid directly to the provider or reimbursed through Medicaid's managed care contracts. Some mental health services, known as community rehabilitation services or state plan option (SPO) rehabilitation services, are provided by Community Services Boards (CSBs). Two of the more common services used by CSA children and provided through the CSBs are the intensive in-home and therapeutic day treatment services.

Additionally, Medicaid provides financial support for children through Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services. EPSDT screening services refer to those screening and diagnosis services used to determine physical

or mental problems for children who are less than 21 years of age. Health care services are provided to correct or improve any problems and conditions discovered, including treatment services for physical and mental illnesses outside the State's covered services. The 1989 federal mandates significantly expanded both the eligibility for EPSDT and the services that were covered, thereby increasing State expenditures.

Use of Medicaid Funding for CSA. A key issue for Virginia's CSA program is whether Medicaid should be used to offset the cost of CSA to both the localities and the State. This possibility has been raised because there are Medicaid-eligible CSA children who are receiving CSA services through a combination of State and local funds for which the State could receive Medicaid reimbursement through federal funds. The replacement of funding sources could permit redirecting current funds to serve more children and/or to curb the growth of the CSA budget. Another advantage of the use of Medicaid funds to cover more CSA services is that the accountability structure of the program — charge structures and billing systems, utilization review practices, quality assurance activities, provider standards, common assessment and common program eligibility — become requirements for CSA.

A 1991 legislative study first discussed in detail the use of Medicaid funds to provide mental health services to "at-risk" children and their families. Since that time, there has been reluctance at both the State and local level to proceed. In a 1997 presentation to the General Assembly, the Department of Medical Assistance Services (DMAS) cited three major issues regarding the expansion of Medicaid services to cover services now paid through CSA:

- Medicaid funding brings with it stringent federal requirements. For example, comparability requirements mandate that any covered service must be available to all eligible children, not just those served by CSA. DMAS does not know at this time how many non-CSA children will use the expanded services.
- Adequate funding with controlled growth must match any mandate to expand Medicaid services. If new services are added, State matching funds must be available. There must be a careful evaluation of where this match will come from and ways to ensure that there will not be an incentive to increase residential placement in order to avoid the expenditure of local funds and shift the cost back to the State.
- Utilization management for quality of care is essential. There must be aggressive monitoring of the providers to ensure that the children receive intensive treatment and are returned to their homes and communities as soon as possible.

The localities have been reluctant to use Medicaid funded services because of the administrative and program changes that go along with the use of federal dollars. These administrative changes, which require increased accountability for services provided and dollars spent on behalf of CSA children, may be seen as contrary to the

original intent of the CSA program — which is to afford the localities flexibility in the design of their CSA programs. Another issue for localities concerns who will be able to authorize Medicaid services and how the match for Medicaid dollars will be managed. One provider association stated that the Medicaid-funded state plan option rehabilitation services, provided through CSBs, limits the multi-agency team's access to Medicaid funds because the authorization and match is tied to the CSBs.

The answer to the question of whether this policy change for Medicaid and CSA is a worthwhile pursuit for the State turns on three issues:

- whether a substantial number of children in CSA are Medicaid-eligible;
- whether a sufficient number of these children receive the type of services that would be reimbursable under Medicaid; and
- whether expanding the Medicaid program to pay for the cost of these services would still result in sufficient savings to the State given the additional number of non-CSA children who may qualify for the expanded service.

The database developed for this study on the characteristics and service utilization of a sample of CSA children provided the Commonwealth's first opportunity to fully address these three issues.

As previously noted, based on the file review data, JLARC staff found that about 68 percent of the children were eligible for Medicaid. Answering the second and third issues, however, required additional analysis and some additional data collection. A detailed discussion of the JLARC staff analysis of these issues and the results is provided in Appendix D of this report. In summary, JLARC staff found that a substantial number of CSA children receive the type of services that would be reimbursable under Medicaid (an estimated 1,378 children receive inpatient medical or outpatient medical care, and an estimated 2,900 children receive residential care or special foster care). Further, even after taking into account potential cost increases due to paying costs for additional non-CSA children who may qualify for the expanded Medicaid services, it is estimated that over \$40 million in State and local savings (about \$25.9 in State and about \$15.4 million in local cost savings) could be achieved.

If it is determined that some of the cost of CSA can be appropriately shifted to the federal government, it is important to note that major issues must be addressed prior to implementation of this strategy. These include: the authorization process to gain access to these services, utilization management for quality of care, and the determination of the source of the general fund match for federal dollars.

Aside from the issue of cost savings generated to the State, the use of Medicaid funds would also improve problems cited throughout this report with the current administration of the CSA program, including:

- uniform assessment and program criteria;

- comprehensive case management services, including the development of care plans, formal monitoring of the care plans, and discharge planning;
- provider standards;
- utilization management for quality of care;
- charge structures and accounting procedures; and
- controlling fees paid to providers.

Medicaid funds could also be used to offset the administrative burden that the localities have cited with the implementation of the CSA program and with the potential use of Medicaid funded services. For example, if the localities implemented a uniform assessment process and level-of-care criteria for CSA funded services, the cost of the assessment and screening process could potentially be reimbursed by Medicaid. Medicaid funded targeted case management services could also be used to reimburse the ongoing case management and multi-agency team activities provided on behalf of Medicaid eligible children. Both of these issues require further exploration by the State Executive Council and the Department of Medical Assistance Services. Despite local requests for analysis in this area, the State Executive Council has not discussed this issue.

The following recommendations are made if the General Assembly decides to facilitate the expansion of the Medicaid program to defray some of the costs of CSA.

Recommendation (12). The State Executive Council, in conjunction with the Department of Medical Assistance Services, should provide technical assistance to the localities on the use of Medicaid-funded inpatient and outpatient mental health services, including program eligibility requirements. The State Executive Council should also develop procedures to ensure that localities seek Medicaid funding prior to the use of CSA funds.

Recommendation (13). The General Assembly may wish to require the Department of Medical Assistance Services to amend its State plan to include Medicaid payment for therapeutic foster care, as well as residential care under EPSDT.

Recommendation (14). The General Assembly may wish to require the Department of Medical Assistance Services to amend its State Plan to include Medicaid payment for assessment services for all children seeking CSA-funded treatment services and targeted case management services for Medicaid-eligible CSA children. The State Executive Council, in conjunction with the Department of Medical Assistance Services, should develop an implementation plan for the use of Medicaid funds for assessment and case management functions.

Recommendation (15). The General Assembly may wish to require that the State Executive Council, in conjunction with the Department of Medical Assistance Services, develop a work group to address the major issues relating to the use of Medicaid funding in lieu of CSA funding for residential and therapeutic foster care services, and as payment for assessment and case management services. The State Executive Council should ensure that the work group develops administrative procedures and regulations that are not burdensome to the localities.

Use of State Beds. Some localities have expressed concern over the cost of treating children in CSA who have severe psychiatric problems. In a few small localities, the total cost of psychiatric care for one child has consumed from a third to almost half of the total CSA budget. Because of the limited number of providers for some children with acute problems, some localities have used facilities in other states at costs of more than \$400 per day. At the same time, the availability of public beds for children and adolescents at State facilities have decreased. As with the Medicaid funding issue, the State Executive Council has not discussed the policy of the use of State beds for youths served in CSA. JLARC staff reviews of Council minutes as well as structured interviews with Office staff show that policy development regarding the use of State beds has been absent from the Council's agenda.

Two significant State-level policy changes have impacted the ability of localities to place CSA children in beds at State facilities. The first policy impacts admissions and the second policy impacts the number of available state beds. The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) currently operates 92 beds in three facilities for children and adolescents experiencing mental health problems: Central State Hospital's adolescent unit; DeJarnette Center; and Southwestern Virginia Mental Health Institute's adolescent unit. The Department also operates five training centers for persons with mental retardation, but none of these centers operate a separate unit for children.

Over the years, DMHMRSAS has shifted its policy on the role of State facilities from providing long-term psychiatric residential care for children to its current role of providing only acute care. While long-term psychiatric residential care may have lasted between 12 to 18 months, acute care is usually 30 days or less. In 1996, the Department published guidelines for the "smooth" transition of clients into and out of State facilities. Children now are only served in the State facilities long enough to stabilize their condition so they can move back into their community. This emphasis on only acute care admissions and the use of alternative community based care services follows a national mental health policy trend.

In 1992, three major budgetary activities at DMHMRSAS reduced by 80 the number of State beds available for the inpatient hospitalization of children in State facilities. First, there was the closing of the adolescent unit at Eastern State. Prior to its closing in 1992, the State paid \$2.7 million to operate this 40-bed unit. The second budgetary effort was the contracting of the Virginia Treatment Center for Children (VTCC) and its 28 beds to the Medical College of Virginia, essentially making it a

private facility. The third budgetary effort was the building of a new 48-bed child and adolescent unit at DeJarnette, with 12 less beds than before.

In 1993, the DMHMRSAS worked with the Department of Medical Assistance Services to expand the use of Medicaid funds, under the EPSDT program, to reimburse free standing hospitals that served children. This service had previously been provided by State hospitals only. This strategy was developed to offset the loss of State beds by expanding access to inpatient psychiatric care for children in facilities close to their communities.

Figure 21 provides the statewide bed capacity for children and admissions trend data for the past six years. As demonstrated by the chart, the State beds for children have been reduced by 52 beds (not including the 28 beds lost from VTCC) since the implementation of CSA. The number of admissions for these beds have remained relatively stable but the high number of admissions given the small number of beds emphasize shorter stays for acute care admissions.

While the change in State's admission policies and number of State beds available for inpatient psychiatric care for children do appear to have shifted some of these costs to localities, reopening the use of State beds is contrary to national and State policies on the need to deinstitutionalize children and serve them in their communities. A better alternative for Virginia is to continue to build community based alternatives to State facility care and to maximize the use of alternative funding, such as Medicaid, to pay for these services.

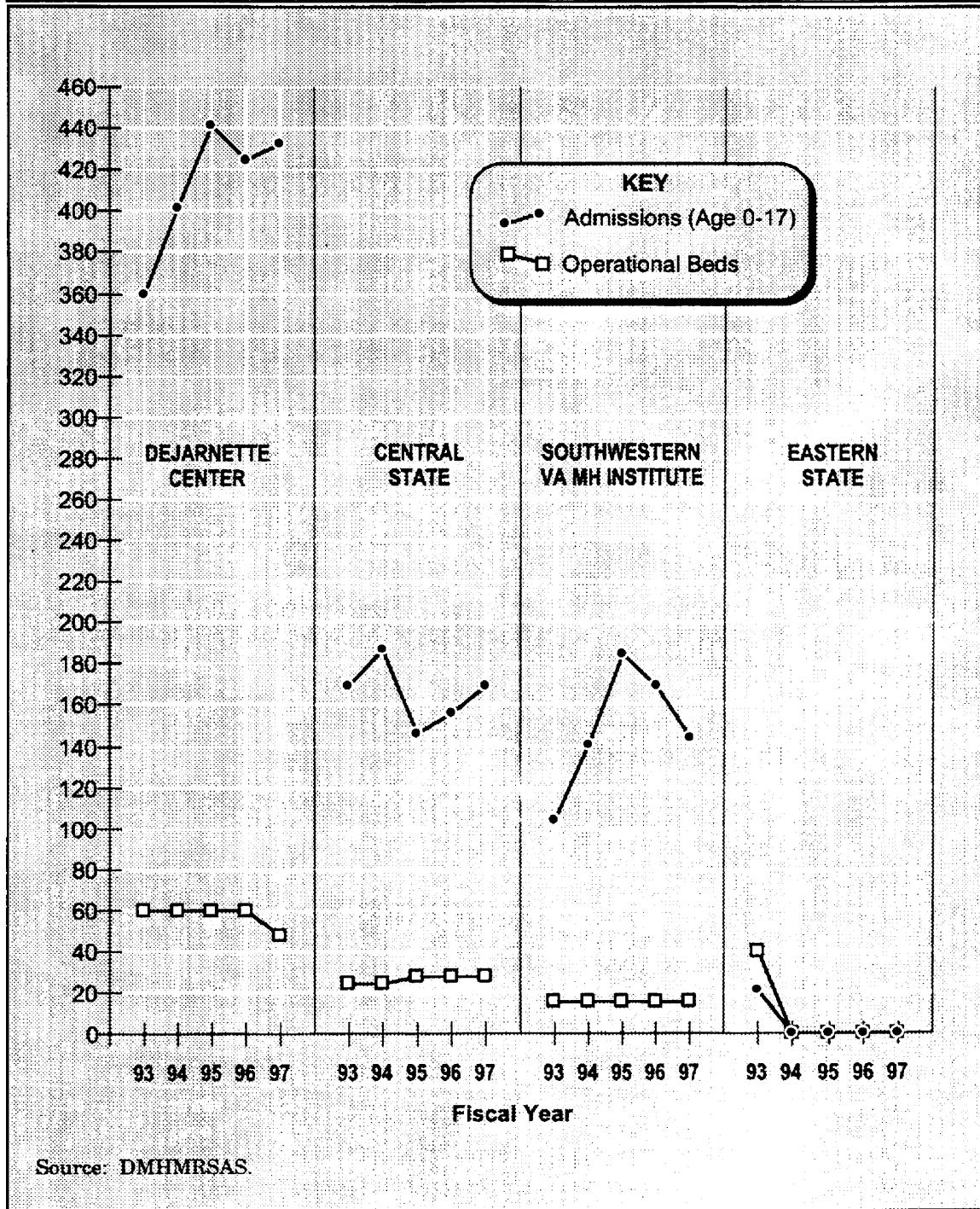
CHANGES NEEDED IN CSA STATE STRUCTURE

One of the reasons CSA was considered such a unique type of program when it was created over five years ago was that it employed a different structure than traditional programs in State government. However, this very structure which was intended to promote collaboration and creative policymaking in State agencies has not had the hoped-for outcomes. Instead, it has resulted in minimal leadership and initiative at the State-level, and overall confusion and inconsistency regarding administrative procedures and responsibilities.

In its present form, the CSA State structure contains a number of barriers which have weakened the ability of the current State-level management to function in a way that is effective for the program. Problems with role clarity and authority, a cumbersome operational structure, and overall program inconsistencies have prevented CSA from operating in the manner envisioned by its architects. JLARC staff identified three major changes which should address these structural problems and improve the overall operation of the CSA program.

Figure 21

Trends in Capacity (Beds) and Admissions for Children in Selected DMHMRSAS Facilities, FY 1993 to FY 1997



Several Major Changes Are Needed to Improve the State-Level Management of CSA

Given the problems observed with the structure and management of CSA at the State level, the following changes could improve the program: (1) restructuring the membership of the State Executive Council to include the director of the Department of Medical Assistance Services; (2) streamlining the State management structure by removing the second tier of management and eliminating duplicative work groups; and (3) realigning the Office of Comprehensive Services by placing it in the Department of Mental Health, Mental Retardation and Substance Abuse Services.

Restructuring the Council. Currently, the membership of the Council includes the agency heads from six State agencies and a representative each for parents, local government, and private vendors. The six represented agencies are the Department of Social Services, the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Department of Education, the Supreme Court of Virginia, the Department of Health, and the Department of Juvenile Justice.

With the pending establishment of utilization management and the development of policies designed to use Medicaid as an alternative funding source, it may be critical that the agency with the responsibility for Medicaid and the expertise in the implementation of a program of utilization management be included on the Council. With the support of the director and access to the resources of this agency, the Council can receive valuable guidance and resource support as it crafts the policies required to incorporate utilization management and the use of Medicaid funds in CSA.

Another aspect of the Council makeup which requires attention is the level of local representation. It would be beneficial for the Council to have two local representatives as members: one who represents the elected local officials who make the funding decisions, and a member of a local community policy and management team. In its current form, the State Executive Council does not have adequate local input, and this has engendered complaints from the localities that their voices are not being heard regarding the needs and problems of the CSA program.

Recommendation (16). **The General Assembly may wish to amend the Code of Virginia to add the chair of a local Community Policy Management Team to the State Executive Council. If a decision is made to establish a closer link between CSA and Medicaid, the General Assembly may also wish to add the Director of the Department of Medical Assistance Services to the Council.**

Streamlining State Structure. JLARC staff recommend a number of structural changes which could increase the productivity and effectiveness of the State-level management of CSA. Given the long-standing problems of the State Management Team — confusion about its role, limited capacity to carry out its technical assistance functions, a poor relationship with the State Executive Council — and the limited benefits produced by this structure, an alternative approach is needed. Thus, to streamline the State-level management of CSA, the State Management Team should be elimi-

nated. Its primary function of technical assistance to the localities can be assumed by the Office of Comprehensive Services, which would be realigned based on the proposals of this report.

Also, because of a lack of organization and the duplication associated with the current State-level work groups, a more streamlined and manageable approach is needed here as well. Rather than have permanent work groups which establish agendas independent of the Council, the system would be better served by requiring the Council to form work groups for specific tasks on an as-needed basis. As agency heads, the members of the State Executive Council can assess which of their employees have the expertise needed for specific tasks. Once the work of that group is completed, it would be disbanded. The ad-hoc status of the work groups would ensure that groups meet with a specific purpose while still utilizing local and State agency input in the decisionmaking process.

Recommendation (17). The General Assembly may wish to amend the *Code of Virginia* to dissolve the State Management Team and authorize the State Executive Council to appoint work groups on an as-needed basis. Among its members, these work groups should include regional representation of local CSA officials and State agency staff. The general operations of these work groups should be under the purview of the Office of Comprehensive Services, as the administrative arm of the State Executive Council. The Office of Comprehensive Services should work in conjunction with these work groups and present subsequent findings and recommendations to the State Executive Council.

Realignment of the Office of Comprehensive Services. A prevalent theme throughout this chapter has been the lack of clarity regarding the responsibilities of the Office of Comprehensive Services. Since the *Code of Virginia* does not officially recognize the Office as an agency of the Commonwealth, the question of what place this entity should have in the overall CSA structure has been recurrent. As it now stands, the Office of Comprehensive Services has a tenuous relationship in the State government structure and no defined place in the hierarchy of CSA.

It is clear that the State-level administration and management of CSA must be simplified. The Office of Comprehensive Services can play an essential role in the operation of CSA at the State level since it has the only State staff with primary responsibilities in this area. Moreover, if the system of financial reporting and oversight that is required for a program the size of CSA is to be fully developed, a cadre of staff working full-time on these issues – not dividing their time across other agencies — will need to be put in place.

At the present time, the office is housed within the Department of Social Services, but this department has no overall responsibility for CSA. The commissioner of that agency has been allocated three new positions to bring its total staff number to seven. However, until the authority of the agency and its position in the State government hierarchy are clearly outlined, the addition of new staff will have a minimal impact on the local implementation of CSA.

The most logical status and location for the Office of Comprehensive Services is as a separate division within the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS). While the children served by CSA have a variety of social, environmental and economic problems, the main criteria for accessing CSA funds is that the child must have persistent behavior or emotional problems that warrant intervention from multiple agencies. DMHMRSAS is the State agency charged with coordinating and developing comprehensive plans for the delivery of publicly funded mental health, mental retardation, and substances abuse services. As such, DMHMRSAS can work with the State Executive Council and the Office of Comprehensive Services to ensure that the administrative policies and procedures developed for CSA complement the Commonwealth's current and future vision of the delivery of mental health services.

This is particularly important as the HJR 240 Joint Subcommittee continues its work on the future delivery of mental health services in the Commonwealth. DMHMRSAS, through the local Community Services Boards and State facilities, has experience in the provision of mental health services to children and adolescents. The Department also has worked closely with the Department of Medical Assistance Services to maximize the use of Medicaid funding for mental health services. Another advantage to the placement of CSA within DMHMRSAS is that its staff has the expertise to provide technical assistance on a variety of mental health issues related to CSA, such as the assessment of emotional and behavioral problems and the development of community services as a less restrictive alternative to institutionalization.

This arrangement maintains the critical component of the original structure of CSA, the need for interagency input, cooperation, and coordination through the State Executive Council. From the State perspective, the problems of the fragmented structure will be corrected and a single agency will be vested with the responsibility of policy development, management, and oversight responsibilities. From the local perspective, there would be one place at the State level to receive technical assistance and training on the CSA policies and procedures. This in turn will allow local agencies to return to their focus on the delivery of services to at-risk youth, rather than reacting to conflicting demands from the State. As a result, the at-risk child and his family will be served in a better, more effective system.

Recommendation (18). The General Assembly may wish to amend the *Code of Virginia* to establish the Commissioner of the Department of Mental Health, Mental Retardation, and Substance Abuse Services as the permanent chair of the State Executive Council.

Recommendation (19). The General Assembly may wish to amend the *Code of Virginia* to establish the Office of Comprehensive Services as a division of the Department of Mental Health, Mental Retardation, and Substance Abuse Services. The Office of Comprehensive Services should act as the administrative arm of the State Executive Council and as such should maintain the operational duties of the CSA program.

Appendixes

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**Appendix A
Study Mandates**

**Senate Joint Resolution No. 123
1996 Session**

**Directing the Joint Legislative and Audit Review Commission to study the
administration of the Comprehensive Services Act.**

WHEREAS, responding to an identified need to recommend changes to the service delivery system for severely emotionally and/or behaviorally disturbed children, the Secretaries of Health and Human Resources, Public Safety, and Education formed an inter-agency council in 1990 which concluded that state and local expenditures on residential care would continue to increase significantly unless major policy and program changes were instituted; and

WHEREAS, over the next two years a study was conducted and preliminary findings from five demonstration projects as well as recommendations for the restructuring of the service delivery system were submitted to the Governor and General Assembly; and

WHEREAS, representatives of the council included state and local staff in the various child-serving agencies, state and local government officials, parents, judges, public and private providers, and advocates covering the spectrum of entities which would feel the impact of such a new system; and

WHEREAS, the intent of the resulting legislation is "to create a collaborative system of services and funding that is child-centered, family-focused and community-based when addressing the strengths and needs of troubled and at-risk youths and their families" through early, least-restrictive, individually-designed, and family-oriented services that cut across all service agencies; and

WHEREAS, to accomplish this, various types of assistance were created to enable localities to develop such a program, including (i) creation of interagency teams at the local and state levels, (ii) development of a state trust fund to provide venture capital for localities to create and expand community-based services, (iii) consolidation of eight categorical funding streams into a pool which is distributed to localities based on a formula, and (iv) provision of technical assistance and training to localities; and

WHEREAS, localities received various assurances with regard to maintenance of state funding, payment for unanticipated costs, and a process was developed for localities to transition into the system; and

WHEREAS, in 1994 because the Comprehensive Services Act was still a relatively new approach and the state and localities were continuing to experience increased costs, the General Assembly approved House Joint Resolution No. 56, directing the Secretaries of

Health and Human Resources, Public Safety and Education to study and evaluate the effectiveness, efficiency and adequacy of state funding; and

WHEREAS, the House Joint Resolution No. 56 study made nineteen recommendations that identified where to invest additional resources and efforts to improve both the effectiveness and efficiency of the Act; and

WHEREAS, statewide, many localities are still experiencing cost and service delivery difficulties, while some local programs have been very successful at controlling costs and achieving improved service levels, now therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Legislative Audit and Review Commission be directed to conduct a study of the administration of the Comprehensive Services Act by the state and local governments, including, but not limited, to examining the information; administrative, financial, and accounting requirements; forecasting of utilization; and delivery of services; and to make recommendations for improvement of program services and strategies for cost containment. The commission shall work in cooperation with the joint subcommittee studying the Comprehensive Services Act pursuant to Senate Joint Resolution No. 93 (1996).

All agencies of the Commonwealth shall provide assistance to the Joint Legislative and Audit Review Commission, upon request.

The Joint Legislative and Audit Review Commission shall complete its work in time to submit its findings and recommendations to the Governor and the 1998 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Implementation of this resolution is subject to subsequent approval and certification by the Joint Rules Committee. The Committee may withhold expenditures or delay the period for the conduct of the study.

Senate Joint Resolution No. 371 1997 Session

Requesting the Joint Subcommittee to Study the Comprehensive Services Act encourage the Joint Legislative Audit and Review Committee include certain issues in its 1997 study of the Comprehensive Services Act.

WHEREAS, the Comprehensive Services Act (CSA) was created in 1992 to establish a comprehensive system of services and funding through interagency planning and collaboration in order to better meet the needs of troubled and at-risk youths and their families; and

WHEREAS, in order to accomplish this in a systematic way, a state pool of funding was created to allow the community policy and management teams and the family assessment teams in the localities to draw upon funding in a manner which would better address the needs of the child and his family; and

WHEREAS, localities received various assurances with regard to maintenance of state funding, payment for unanticipated costs, and a transition process for localities to evolve into the system; and

WHEREAS, increases in the cost of services and in the number of youths who need services has placed a severe strain on existing resources, and future scheduled appropriations do not appear to meet the anticipated needs; and

WHEREAS, total costs for fiscal year 1996 are now estimated at \$145 million; and

WHEREAS, some localities are experiencing cost and service delivery difficulties and are apprehensive about the possibility that additional costs are going to be passed on to the localities; and

WHEREAS, the Joint Subcommittee to Study the Comprehensive Services Act heard testimony and received information which has offered some insight into the problems, and also received some information about how to begin to address such issues; and

WHEREAS, the Joint Legislative Audit and Review Commission's study of the Comprehensive Services Act, pursuant to SJR 123 (1996), is not due to be completed until 1998; and

WHEREAS, the joint subcommittee, after identifying a number of potential issues, felt that it would be premature to offer legislation or other corrective measures in light of the pending JLARC study; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Subcommittee to Study the Comprehensive Services Act encourage JLARC to examine some of these same issues in their study, including (i) the development of financial incentives for localities which implement "best practices," including the appointment on each community policy and management team of a local fiscal agent, the increased collection of a minimum financial contribution by parents of children receiving CSA services, the degree to which services which are being provided by private facilities can be provided at state facilities, and the degree to which localities are able to successfully implement treatment and management goals; (ii) the issue of access through the Juvenile and Domestic Relations judges for those youths who may not be considered "mandated" by law; (iii) clarification of which services are federally or state mandated; (iv) evaluation of a process through which each placement is reviewed every six months to see if appropriate progress is being made and if other alternatives may be more appropriate; (v) the need for more technical assistance for the localities from the state CSA office, which currently has only two and one-half positions; and (vi) the exploration of the coordination of CSA funds with other funding streams, such as the Juvenile Community Crime Control Act funds, in order to leverage additional funds.

Item 14J of the 1997 Appropriations Act

COMPREHENSIVE SERVICES ACT FORECAST MODEL

The study of the Comprehensive Services Act, pursuant to Senate Joint Resolution 123 of the 1996 Session of the General Assembly, shall not include the development of a forecast model. The study shall include an evaluation of the Comprehensive Services Act, including: (1) an assessment of the management of the program at the state level; (2) an evaluation of the local implementation of the program; (3) an analysis of the local variation in caseloads and the unit costs of the program; and (4) an assessment of the effectiveness of the Comprehensive Services Act.

Appendix B

CSA Best Practices

The recommendations presented in this report can improve the efficiency and effectiveness of the CSA program for local governments that have the responsibility of implementing CSA. While these recommendations point out current shortcomings with the way CSA is implemented overall, this report would be remiss if it did not point out that some localities have already adopted policies which embody some of the recommendations presented in this report. It is also important to note that the localities that have been identified by JLARC staff as exhibiting "best practices" utilize CSA coordinator positions in their implementation of CSA. These positions appear to be valuable to the implementation of "best practices."

Exhibit B outlines some of the "best practices" that are implemented in the 22 localities whose CSA programs were reviewed by JLARC staff. These practices have been categorized according to the particular component of case management in which they represent. These components include three basic steps: 1) preliminary screening and eligibility determination; 2) needs assessment and service plan development and implementation; 3) selecting service providers; and 4) monitoring of the child and the services provided.

The list of localities discussed in the attached exhibit is not meant to be exhaustive. In other words, there are localities that are not mentioned that have embraced some of the policies discussed in this report. At the same time, some of the localities that are mentioned may have successfully implemented a "best practice" for one area of the CSA eligibility and case management process but not others. While localities should retain the discretion needed to develop programs to serve troubled children, the Office of Comprehensive Services could develop incentive programs to encourage local use of some of the policies discussed in this section of the report.

Examples of Best Practices Identified During the Review

| CSA Stages of Implementation | Program Elements | Examples of Local "Best Practices" |
|--|--|---|
| <p>Preliminary Screening and Eligibility Process</p> | <ul style="list-style-type: none"> • Perform preliminary evaluation of a child's needs to determine the child's likelihood of needing CSA services. • Thorough multi-agency review process, ensure that the child meets the CSA program eligibility criteria, including that all other agency resources have been exhausted. • Maximize the use of alternative funding sources, such as Medicaid, Supplemental Security Income (SSI), Title IV-E, and parental co-payment responsibilities, to reduce CSA expenditures. | <ul style="list-style-type: none"> • Henrico and Prince William counties use a pre-screening team to ensure that community and agency resources have been exhausted prior to bringing the child's individualized service plan to the multi-agency team to gain access to CSA-funded services. These teams consist of people who best know the needs of the child, and the teams often attempt to access the most appropriate service for the child without accessing CSA funds. • Hampton's multi-agency team requires the referral agency to demonstrate that all resources to treat the child have been exhausted prior to seeking CSA funds. This is partially accomplished by the CSA coordinator who screens each case prior to bringing it before the multi-agency team. • In order to ensure referrals from the schools involving special education children undergo a multi-agency approach, Norfolk has established a special education assessment team. All cases of this nature requesting CSA funds must be reviewed by this team, and the team has the authority to develop IEPs. • Henrico County brings <u>all</u> cases requesting CSA treatment funds to the multi-agency process. This ensures that costs are controlled and that individual case managers do not have funding authority. In addition, it removes inconsistencies from the eligibility determination process. • Staunton aggressively pursues the use of federal funds (Title IV-E) as payment for foster care as a means of reducing the need for CSA funds. The locality accomplishes this by requesting all case workers review past cases (over a two year period) and all current foster care cases for possible IV-E funding opportunities. • Hampton conducts an assessment of each case to determine if Medicaid funds can be combined with CSA dollars to offer a child the full range of services need. If Medicaid only pays for a portion of the care prescribed by the multi-agency team, Hampton uses CSA funds to cover the remaining costs. |

Examples of Best Practices Identified During the Review, continued

| <p>CSA Stages of Implementation</p> <p>1. Assessment 2. Care Planning 3. Service Provision</p> | <p style="text-align: center;">Program Elements</p> <ul style="list-style-type: none"> • Develop a care plan for each child that includes the child's needs, goals, and services. The care plan should be developed in collaboration with the child's family and other service providers. The care plan should be reviewed and updated as needed. • Develop a family care plan that includes goals and objectives for the child and family. This should be done in collaboration with the family and other service providers. This should include identifying strengths and needs of the family and setting objective goals and outcomes for the child. • Develop a transition plan with all service providers to ensure that CSA children are moved on a timely basis to less restrictive and less costly service alternatives. • Multi-agency team develops and/or authorizes the services outlined in the care plan. | <ul style="list-style-type: none"> • The City of Richmond has developed a "profile summary" for a child needing services and distributes this to potential providers. Providers respond with preliminary service plans and cost estimates. In addition, the City has, through the use of proposals, developed 24 hour crisis stabilization facilities and alternative services for hard to place children. |
|---|--|---|
| <p>Selecting Service Providers</p> | <ul style="list-style-type: none"> • Develop local and/or regional methods for negotiating provider fees/services. Identify cost-effective residential providers. • Develop cost effective community-based alternatives for mental health services. | <ul style="list-style-type: none"> • The City of Richmond is developing a baseline assessment process to provide information needed for developing specific outcome objectives, measure the progress the child makes in treatment, and provide uniform data on all CSA children. |

Examples of Best Practices Identified During the Review, continued

| CSA Stages of Implementation | Program Elements | Examples of Local "Best Practices" |
|-------------------------------------|--|--|
| Monitoring of Child's Services | <ul style="list-style-type: none"> • Case manager maintains regular contact with the child, the family/guardian and service providers in order to ensure that the services are appropriate, of high quality, and are meeting the child's needs. • Conduct formal periodic reviews of child's status to determine whether the child's needs have changed in relation to the goals established in the care plan. • Conduct a systematic evaluation or utilization review to determine how well the program is meeting its stated goals. | <ul style="list-style-type: none"> • In Fairfax County, the multi-agency team periodically conducts full reassessments of authorized services and funding decisions. The frequency of these reassessments depend on the stability of the situation, the restrictiveness of the service, and the cost of the service. • In Henrico, the CSA coordinator interviews and screens each private provider prior to adding them to the county's vendor list. At the onset of each service contract, the team provides the provider with set goals, objectives and timeframes for the treatment plan for a CSA child. Monthly visits to residential providers are conducted as needed. • Fairfax County's also monitors services through the computerization of basic CSA client information which tracks the characteristics, service utilization and costs over time. |

Appendix C

1/1/97

Childhood Severity of Psychiatric Illness

Manual

**Mental Health Services and Policy Program
Department of Psychiatry & Behavior Science
Northwestern University Medical School
and the
Department of Child and Adolescent Psychiatry
Children's Memorial Hospital**

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Childhood Severity of Psychiatric Illness

About the Measure

The Childhood Severity of Psychiatric Illness (CSPI) is an assessment tool developed to assist in the management and planning of mental health services for children and adolescents. Developed as a decision support tool for case managers and clinical decision-makers, the CSPI provides for the structured assessment of children with possible mental health service needs along a set of dimensions found to be relevant to clinical decision making. In addition, the measure is designed to provide information regarding children's mental health needs for utilization during service system planning and quality assurance monitoring.

The dimensions and objective anchors used in the CSPI were developed through focus groups with a variety of participants including representatives of the provider community and DCFS case workers and staff. From these discussions, pilot instruments were developed and tested in a number of sites. The reliability of the CSPI has been found to be quite high for trained raters and the dimensions have been shown to reliably predict both mental health service use and clinical outcomes.

A summary of the dimensions of the CSPI can be found below. Each of these dimensions is rated on 4-point scales after routine clinical contact or following review of case files. Although the anchors of each of these scales varies, the basic design is that a zero reflects no evidence, a rating of one reflects a mild degree of the dimension, a rating of 2 reflects a moderate degree and a rating of 3 reflects a severe or profound degree of the dimension. The basic structure of the CSPI is as follows:

Symptoms:

- Neuropsychiatric Disturbance
- Emotional Disturbance
- Conduct Disturbance
- Oppositional Behavior
- Impulsivity
- Contextual Consistency of Symptoms
- Temporal Consistency of Symptoms

Risk Factors*:

- Suicide Risk
- Danger to Others
- Elopement Risk
- Crime/Delinquency
- Sexual Aggression

Functioning:

- School Dysfunction
- Family Dysfunction
- Peer Dysfunction

Co-morbidity:

Adjustment to Original Trauma/Separation
Medical
Substance Abuse
Severity of Abuse
Sexual Development
Learning and Developmental Disabilities

Systems Factors:

Caregiver Ability to Provide Supervision
Caregiver Motivation for Change
Caregiver Knowledge of Child
Placement Safety
Community Capacity for WRAP Services
Multi-System Needs

***For Risk Factors, use 7 days prior to admission for rating. For all other scales, use 30 days prior to admission.**

For more information, please contact:

**John S. Lyons, Ph.D.
Director
Mental Health Services and Policy Program
Department of Psychiatry & Behavioral Sciences
Northwestern University Medical School
303 E. Chicago Avenue, Ward 9-217
Chicago, Illinois 60611**

**312-908-8972
312-503-0466 (fax)
jsl329@nwu.edu (e-mail)**

SEVERITY OF PSYCHIATRIC ILLNESS--CHILD & ADOLESCENT
Definitions of Item Rating Levels
SYMPTOMS

Neuropsychiatric Disturbance. This dimension is used to rate symptoms of psychiatric disorders with a known neurological base. DSM-IV disorders included on this dimension are Schizophrenia, Psychotic disorders (unipolar, bipolar, NOS), Autism, and some encephalopathies. The common symptoms of these disorders include hallucinations, delusions, unusual thought processes, strange speech, bizarre/idiosyncratic behavior.

- 0 This level indicates a child with no evidence of thought disturbances. Both thought processes and content are within normal range.
- 1 This level indicates a child with evidence of mild disruption in thought processes or content. The child may be somewhat tangential in speech or evidence somewhat illogical thinking (age inappropriate). This level also includes children with a history of hallucinations but none currently. This category would be used for children who are subthreshold for one of the DSM diagnoses listed above.
- 2 This level indicates a child with evidence of notable disturbance in thought process or content. The child may be somewhat delusional or have brief or intermittent hallucinations. The child's speech may be, at times, quite tangential or illogical. This level would be used for children who meet the diagnostic criteria for one of the disorders listed above.
- 3 This level indicates a child with severe thought disorder. The child frequently experiences symptoms of psychosis and frequently has no reality assessment. There is evidence of ongoing delusions or hallucinations or both. Command hallucinations would also be coded here. This level is used for extreme cases of the diagnoses listed above.

Schizophrenia

A. Characteristic Symptoms:

(Two or more of the following, unless severe delusions or hallucinations, for a significant portion of time during a one month period):

- delusions
- hallucinations
- disorganized speech
- grossly disorganized or catatonic behavior
- negative symptoms (i.e. affective flattening)

B. Social/Occupational Dysfunction:

Failure to achieve expected level of self-care or interpersonal, academic, or occupational achievement.

C. Duration:

Continuous signs of the disturbance persist for at least six months (must include at least one month of symptoms, unless successfully treated).

Autism

A. Characteristic Symptoms:

(Six or more items with at least two from (1), and one from (2) and (3)).

1) Impairment in Social Interaction:

- marked impairment in the use of multiple nonverbal behaviors
- failure to develop peer relationships
- lack of shared enjoyment, interests, or achievements with other people
- lack of social or emotional reciprocity

2) Impairments in Communication:

- delay or total lack of development of spoken language
- impairment in ability to initiate or sustain a conversation
- stereotyped and repetitive or idiosyncratic use of language
- lack of age-appropriate make-believe or social imitative play

3) Restricted Repetitive and Stereotyped Patterns of Behavior,

Interests, and Activities:

- preoccupation with stereotyped and restricted patterns of interests that is abnormal in intensity or focus
- inflexible adherence to routines or rituals
- stereotyped and repetitive motor mannerisms
- persistent preoccupation with parts of objects

B. Delays or Abnormal Functioning:

(Onset prior to age 3)

- social interaction
- language as used as social communication
- symbolic or imaginative play

Emotional Disturbance This dimension is used to rate symptoms of the follow psychiatric disorders as specified in DSM-IV: Depression (unipolar, dysthymia, NOS), Bipolar, Intermittent Explosive Disorder, Generalized Anxiety, Eating Disorders, Phobias. Symptoms included in this dimension are depressed mood, social withdrawal, anxious mood, sleep disturbances, weight/eating disturbances, loss of motivation.

- 0 This rating is given to a child with no emotional problems. No evidence of depression or anxiety.
- 1 This rating is given to a child with mild to moderate emotional problems. Brief duration of depression, irritability, or impairment of peer, family, or academic functioning that does not lead to gross avoidance behavior. This level is used to rate either a mild phobia or anxiety problem or a subthreshold level of symptoms for the other listed disorders.
- 2 This rating is given to a child with a moderate to severe level of emotional disturbance. This could include major conversion symptoms, frequent anxiety attacks, obsessive rituals, flashbacks, hypervigilance, depression, or school avoidance. Any diagnosis of anxiety or depression should be coded here (regardless of severity). This level is used to rate children who meet the criteria for an affective disorder listed above.
- 3 This rating is given to a child with a very severe level of emotional disturbance. This would include a child who stays at home or in bed all day due to anxiety or depression or one whose emotional symptoms prevent any participation in school, friendship groups, or family life. More severe forms of anxiety or depressive diagnoses would be coded here (e.g., meeting criteria in excess of the diagnosis). This level is used to indicate an extreme case of one of the disorders listed above.

Generalized Anxiety Disorder

A. Excessive anxiety and worry about a number of events or activities (occurring more days than not for at least six months).

B. Worry is difficult to control

C. Characteristic Symptoms:

(One or more of the following):

- restlessness
- easily fatigued
- difficulty concentrating
- irritability
- muscle tension
- sleep disturbance

Major Depressive Disorder

A. Characteristic Symptoms:

(5 or more of the following present during a two-week period. Must include either depressed mood or loss of interest or pleasure):

- depressed or irritable mood (most of the day, nearly every day)
- markedly diminished interest or pleasure in activities (most of the day, nearly every day)
- significant weight loss or gains (or failure to meet expected weight gains)
- insomnia or hypersomnia nearly every day
- psychomotor agitation or retardation nearly every day
- fatigue
- feelings of worthlessness or inappropriate guilt nearly every day
- diminished ability to think or concentrate or indecisiveness nearly every day
- recurrent thoughts of death, suicidal ideation or attempt

Conduct Disturbance (Antisocial behavior)

This dimension includes the symptoms of conduct disorder as specified in DSM-IV. These symptoms include antisocial behaviors like shoplifting, lying, vandalism, cruelty to animals, assault.

- 0 This level indicates a child with no evidence of behavior disorder.
- 1 This level indicates a child with a mild or moderate level of conduct problems. Some difficulties in school and home behavior. Problems recognizable but not notably deviant for age and sex and community. This might include occasional truancy, lying or petty theft from family.
- 2 This level indicates a child with a moderate to severe level of conduct disorder. This could include episodes of planned aggressive or other anti-social behavior. A child rated at this level should meet the criteria for a diagnosis of conduct disorder.
- 3 This level indicates a child with a very severe conduct disorder. This could include frequent episodes of unprovoked, planned aggressive or other anti-social behavior.

Conduct Disorder (Three or more of the following in the last 12 months w/ at least one in the last 6 months):

Aggression to people and animals

- bullies, threatens, or intimidates others
- initiates physical fights
- has used a weapon that can cause serious physical harm to others
- has been physically cruel to people
- has stolen while confronting a victim (mugging, extortion, armed robbery, purse snatching)
- has forced someone into sexual activity

Destruction of Property:

- engaged in fire setting with the intention of causing serious damage
- has deliberately destroyed others' property

Serious Violations of Rules

- often stays out at night despite parental prohibitions (beginning before age 13)
- has run away from home overnight at least twice (or once without returning for a lengthy period)
- often truant from school (beginning before age 13)

Deceitfulness of Theft

- has broken into someone's house, building, car
- lies to obtain goods or favors (i.e. "cons" others)
- has stole items of nontrivial value without confronting victim

Oppositional Behavior (Compliance with authority)

This dimension is intended to capture how the child relates to authority. Oppositional behavior is different from conduct disorder in that the emphasis of the behavior is on non-compliance to authority rather than on seriously breaking social rules, norms, and laws.

- 0 This level indicates that the child is generally compliant.
- 1 This level indicates that the child is occasionally noncompliant to some rules or adult instructions.
- 2 This level indicates that the child is frequently noncompliant to rules or adult instructions. A child rated at this level should meet the criteria for Oppositional Defiant Disorder in DSM-IV.
- 3 This level indicates that the child is virtually always noncompliant to rules or adult instructions. A child rated at this level would be a severe case of Oppositional Defiant Disorder.

Oppositional Defiant Disorder

A. Characteristic Symptoms:

(4 or more of the following for at least 6 months):

- often loses temper
- often argues with adults
- often actively defies or refuses to comply with adults' requests or rules
- often deliberately annoys people
- often blames others for his or her mistakes or misbehavior
- is often touchy or easily annoyed by others
- is often angry or resentful
- is often spiteful or vindictive

Impulsivity

In addition to impulsive behavior, symptoms of Attention Deficit and Hyperactivity Disorder and Impulse Control Disorder would be rated here. Inattention/distractibility not related to opposition would also be rated here.

- 0 This rating is used to indicate a child with no evidence of impulse control problems.
- 1 This rating is used to indicate a child with some evidence of mild problems with impulse control. This could be infrequent impulsive action that does not pose notable safety risk, but where the child clearly did not consider consequences. Occasional tantrums or angry outbursts might be rated here.
- 2 This rating is used to indicate a child with considerable impulse control problems. Frequent impulsive behavior is observed or reported that carries some safety risk. A child who meets DSM-IV diagnostic criteria for ADHD or Impulse Control Disorder would be rated here.
- 3 This rating is used to indicate a child with severe impairment of impulse control. Frequent impulsive behavior is observed or noted that carries considerable safety risk (e.g. running into the street, dangerous driving or bike riding). A child with profound symptoms of ADHD or Impulse Control Disorder would be rated here.

ADHD

A. Characteristic Symptoms:

(6 or more of the following for at least 6 months):

Inattention Often:

- fails to pay attention to details or makes careless mistakes in schoolwork, or other activities
- has difficulty sustaining attention in tasks or play
- does not seem to listen when spoken to
- does not follow through on instructions and fails to finish schoolwork or chores
- has difficulty organizing tasks and activities
- avoids tasks that require sustained mental effort
- loses things necessary for tasks or activities
- easily distracted by extraneous stimuli
- forgetful in daily activities

Hyperactivity Often:

- fidgets with hands or feet or squirms in seat
- has difficulty remaining seated when expected
- runs and climbs excessively or subjective feelings of restlessness
- has difficulty playing quietly
- is "on the go" or acts as if "driven by a motor"
- talks excessively

Impulsivity Often:

- blurts out answers during questions
- has difficulty awaiting turn
- interrupts or intrudes on others

B. Some symptoms present before age 7.

C. Some impairment present in two or more settings.

Impulse Control Disorders Symptoms:

Several discrete episodes of failure to resist:

- aggressive impulses that result in serious
- assaultive acts or destruction of property
- impulses to steal objects that are not needed
- impulses to deliberately, purposefully set fires

Contextual Consistency of Symptoms

- 0 This level is used for a child who is symptomatic primarily in one location (e.g. school or home only) and minimally symptomatic in another setting.
- 1 This level is used for a child who is symptomatic in an unstructured setting but who becomes minimally symptomatic when placed in highly structured settings.
- 2 This level is used to represent a child who is symptomatic across most settings regardless of structure or circumstance, but who demonstrates notable variability in symptom type or intensity by context.
- 3 This level indicates a child who is consistently symptomatic regardless of environmental context.

Temporal Consistency of Symptoms

- 0 This level indicates a child who is not symptomatic or who has developed symptomatology only in the past three months as the result of a clear stressor.
- 1 This level indicates a child who has become symptomatic in the past two years but has remained at least somewhat symptomatic during this time or a child who has become symptomatic in the past three months despite the absence of any clear stressors.
- 2 This level indicates a child who has been symptomatic for an extended period of time (e.g. more than two years), but who has had significant symptom-free periods.
- 3 This level indicates a child who has been symptomatic for an extended period of time (e.g. more than two years) without significant symptom-free periods.

RISK FACTORS

Suicide Risk

- 0 This rating is given to someone with no known history of either suicide attempts or ideation.
- 1 This rating is given to someone with (1) no current suicidal ideation, (2) no recent suicide attempts (last 7 days), and (3) a known history of either a suicide attempt or ideation.
- 2 This rating is given to someone with (1) current evidence of suicidal ideation or preoccupation including talking about death and threatening to kill oneself, (2) no recent suicide attempt (last 7 days) OR a prior suicide attempt in the last 7 days with no suicidal ideation in the past 48 hours.
- 3 This rating is given to someone with a recent suicide attempt (last 7 days) regardless of the potential lethality of the attempt AND current active suicidal ideation in the last 48 hours.

Danger to Others

- 0 This rating is given to someone with (1) no current physical aggressiveness (last 7 days) towards either people or property, (2) no current verbal aggressiveness, and (3) no known history of aggressive acts to either people or property.
- 1 This rating is given to someone with (1) no current physical aggressiveness but either (2) current (last 7 days) verbal aggressiveness (but not homicidal) or (3) a known history of aggressive acts to either people or property.
- 2 This rating is given to someone who is currently physically aggressive towards property or people regardless of verbal aggressiveness, but not at a level that risks significant injury (hospitalization) or death.
- 3 This rating is given to someone who is either currently (last 7 days) physically aggressive towards people to the extent that there is risk of causing significant injury or death or expressing homicidal threats or ideation. Command hallucinations to kill or injure someone would be coded here.

Elopement Risk. In general to classify as a runaway or elopement, the child is gone overnight or very late into the night. The exceptions to this would be runaway attempts where the child is found and returned quickly although it was clear that he/she intended to remain away for an extended period.

- 0 This rating is for a child with no history of running away and no ideation involving escaping from the present living situation and/or treatment.
- 1 This rating is for a child with no recent history of running away but who has expressed ideation about escaping present living situation or treatment. Child may have threatened running away on one or more occasions or have a history (lifetime) of running away but not in the past year.
- 2 This rating is for a child who has run away from home once or run away from one treatment setting within the past year. Also rated here is a child who has run away to home (parental or relative) in the past year.
- 3 This rating is for a child who has (1) run away from home and/or treatment settings within the last 7 days or (2) run away from home and/or treatment setting twice or more overnight during the past 30 days. Destination is not a return to home of parent or relative.

Crime/Delinquency

- 0 No evidence of criminal or delinquent behavior or history.
- 1 No current evidence of criminal or delinquent behavior in the past year but a prior history. Minor vandalism (less than \$500) might be rated here even if in last 30 days.
- 2 Evidence of criminal or delinquent behavior in the past year although child not actively engaged in criminal behavior. This could include significant acts of vandalism (more than \$500). No known gang affiliation.
- 3 Recent evidence of criminal or delinquent behavior (last 30 days) or a child or adolescent with known gang affiliation.

Sexual Aggression

- 0 This level indicates a child or adolescent who has never been sexually aggressive or coerced another child or adolescent into sexual activity. No evidence of any history or current sexual aggression.
- 1 This level indicates a child or adolescent who has previously been sexually aggressive or coerced another child but has successfully completed a treatment program. None of the prior sexual activity involved forced or coerced intercourse or penetration.
- 2 This level is used to indicate a child or adolescent who has either (1) a history of sexual aggression that included forced or coerced intercourse/penetration but has successfully completed a treatment program or (2) has been sexually aggressive or coerced another child into sexual activity in the past year not including forced or coerced intercourse or penetration.
- 3 This level indicates a child or adolescent who has been sexually aggressive in the past year and has engaged in forced or coerced intercourse or penetration during this time.

FUNCTIONING

School Dysfunction

- 0 This rating is used to indicate a child who is performing at his/her appropriate level in school or less than school age.
- 1 This rating is used to indicate a child who is having mild to moderate problems at school. This could include underachievement, discipline problems, or a child in a special school doing well.
- 2 This rating is used to indicate a child with serious school difficulties that may include school suspension, frequent truancy, significant discipline problems, and/or underachievement (at the level of failing a grade).
- 3 This level indicates a child with very severe school problems. This could include failure to attend, dangerous discipline problems, a child not in school who is of school age, or a child in a special school who continues to have significant problems.

Family Dysfunction (rated based on individuals, including non-family members, living at home)

- 0 This level indicates a family that is functioning without notable problems. Conflicts arise but are handled appropriately. Communication is adequate. Roles, hierarchies, and boundaries are clear.
- 1 This rating is used to indicate a family with mild to moderate dysfunction. This could include considerable unresolved conflict, blurred or inappropriate hierarchies and/or boundaries (e.g. parents pull children into their marital conflict).
- 2 This level indicates a seriously dysfunctional family. This could include potentially dangerous conflict, serious acting out by family members, and very poor communication.
- 3 This level indicates a severely dysfunctional family characterized by abuse and/or violence or extremely inappropriate communication. Lack of provision of basic needs for child.

Peer Dysfunction

- 0 This rating is used to indicate a child with appropriate peer relations. He/she has at least one identifiable close friend and good relations with other peers.
- 1 This level indicates a child with mild to moderate dysfunction in peer relations. This may include an absence of any close friend, conflictual relationships, or withdrawal from peers.
- 2 This level indicates a child with serious dysfunction in peer relationships. The child may be a 'loner' with few social contacts or may have very conflictual relationships with most peers.
- 3 This level indicates a child with very severe dysfunction in peer relationships. This would include violence towards peers or a complete absence of meaningful social contact or exclusive association with a highly deviant peer group (e.g., gang involvement).

CO-MORBIDITY

Adjustment to Trauma/Separation

- 0 Child appears to have adjusted to separation from parent(s) without significant psychological effects.
- 1 Child has some mild adjustment problems to separation from parent(s) or as result of earlier abuse. Child may be somewhat distrustful or unwilling to talk about parent(s).
- 2 Child has marked adjustment problems associated either with separation from parent(s) or with prior abuse. Child may have nightmares or other notable symptoms of adjustment difficulties.
- 3 Child has post-traumatic stress difficulties as a result of either separation from parent(s) or prior abuse. Symptoms may include intrusive thoughts, hyper-vigilance, constant anxiety, and other common symptoms of PTSD.

PTSD

A. Traumatic Event:

(Both of the following are present):

- person exposed to traumatic event(s) in which actual or threat of death or serious injury to self or other.
- person's response involved intense fear, helplessness, or horror (may be expressed by children as disorganized or agitated behavior)

B. Persistent Re-experience of Event:

(1 or more of the following):

- recurrent, intrusive distressing recollections of event and may engage in repetitive play or daydreams in which themes or aspects of the trauma are expressed
- frightening dreams with or without specific content
- acting or feeling as if the traumatic event were recurring
- psychological distress at exposure to internal or external cues that resemble an aspect of the traumatic event
- physiological reactivity on exposure to internal or external cues that resemble traumatic event

C. Avoidance of Related Stimuli or Numbing of Responsiveness: (3 or more of the following):

- avoids conversations, thoughts, feelings associated with the trauma
- avoids activities, places or people reminiscent of trauma
- can't remember aspects of the trauma
- decreased interest/participation in normal activities
- feelings of detachment or estrangement
- restricted range of affect
- sense of foreshortened future

D. Persistent Symptoms Post Trauma:

(2 or more of the following):

- difficulty falling or staying asleep
- irritability or outbursts of anger
- difficulty concentrating
- hypervigilance
- startles easily

E. Duration:

Symptoms for greater than one month

Medical

- 0 This rating is for someone who has no notable medical problems. A mild, untreated medical problem that does not affect the person's psychological status would be coded here.
- 1 This rating is for someone with mild to moderate medical problems that require treatment but are relatively independent of the psychiatric illness (e.g. sinusitis, broken arm).
- 2 This rating is for someone with a moderate to serious medical problem that both requires treatment and represents a mild to moderate complication to psychiatric treatment (e.g., diabetes, asthma, heart valve problem, or seizures). Non-symptomatic HIV infection would be rated here.
- 3 This rating is for someone with a life threatening medical condition that presents a significant complication to treatment management (e.g. cancer, leukemia, AIDS, or severe malnutrition secondary to anorexia).

Substance Abuse

- 0 This rating is for someone who has no notable substance use difficulties at the present time. If the person is in recovery for greater than 1 year, they should be coded here, although this is unlikely for a child or adolescent.
- 1 This rating is for someone with mild to moderate substance use problems that might occasionally present problems of living for the person (intoxication, loss of money, reduced school performance, parental concern). This rating would be used for someone early in recovery (less than 1 year) who is currently maintaining abstinence.
- 2 This rating is for someone with a moderate to serious substance abuse problem that both requires treatment and interacts with and exacerbates the psychiatric illness. Substance abuse problem consistently interferes with the ability to function optimally but does not completely preclude functioning in an unstructured setting.
- 3 This rating is for someone with an extreme substance dependence condition that presents a significant complication to the inpatient management (including need for detoxification, substance abuse in residential facility, and so forth).

Severity of Abuse / Neglect

- 0 This level is used to indicate a child with no history of any form of physical or sexual abuse, nor any history of neglect.
- 1 This level is used to indicate a child with a history of mild abuse or neglect. This could include a child who is occasionally hit or touched inappropriately. Occasional neglect would also be rated here such as leaving a child at home with no adult supervision.
- 2 This level is used to indicate a child with a moderate level of abuse. This would include a child who has been fondled on an ongoing basis but not penetrated. However, this might also include a child who has been penetrated on one occasion. This would also include a child who is physically abused on an ongoing basis and may require medical attention.
- 3 This level is used to indicate a child with a severe history of abuse. This would include a child who has been sexually penetrated on multiple occasions and over an extended period or forced to perform sexual acts on other children or adults. This would also include a child who has been severely physically abused to the point where the child requires serious medical attention (e.g., hospitalization) This level would also indicate a child who has experienced extreme neglect (e.g., severe malnutrition, starvation).

Sexual Development

- 0 This level indicates a child engaging in age appropriate sexual activity. There is no evidence of disrupted sexual development.
- 1 This level indicates a mild disruption in sexual development. This might include some sexually inappropriate activity for the child's developmental stage. An adolescent who is experiencing distress from homosexual urges or impulses might be rated here.
- 2 This level indicates a moderate disruption in sexual development. This could include over-sexualized behavior or an absence of any sexual interest in an adolescent.
- 3 This level indicates a severe disruption in sexual development. This could include grossly inappropriate sexual behavior for age, **not** including sexual aggression. Multiple older partners might be rated here.

Learning Disability/Developmental Delay

- 0 This level indicates a child with no evidence of any learning disabilities or developmental delay
- 1 This level indicates a child with a mild to moderate learning disability that is likely to make academic achievement more challenging but is not severe enough to require a special school environment. Child's IQ is expected to be greater than 85.
- 2 This level indicates a child with a severe learning disability or a developmental disability that would require a special education environment in order for the child to learn. Child's IQ would be expected to be between 70 and 85.
- 3 This level indicates a child with a profound developmental disability that likely seriously limits the child's academic development. Child's has an IQ of less than 70.

SYSTEM FACTORS

Caregiver Ability to Provide Supervision. This rating should be based on the caregiver's ability to manage behavior and set appropriate limits

- 0 This rating is used to indicate a caregiver circumstance in which supervision and monitoring is appropriate and well-functioning.
- 1 This level indicates a caregiver circumstance in which supervision is generally adequate but inconsistent. This may include a placement in which one member is capable of appropriate monitoring and supervision but others are not capable or not consistently available.
- 2 This level indicates a caregiver circumstance in which supervision and monitoring are very inconsistent and frequently absent.
- 3 This level indicates a caregiver circumstance in which appropriate supervision and monitoring are nearly always absent or inappropriate.

Caregiver Motivation for Change

- 0 This rating is used to indicate a caregiver that is motivated to make changes necessary to solve present problems. This would also include a placement that is actively involved in child's treatment or treatment planning.
- 1 This level indicates a caregiver circumstance in which at least one member is motivated for change. Other members are ambivalent or uninterested. This would also include some evidence of noncompliance with treatment recommendations for child.
- 2 This rating is used to indicate a circumstance in which the caregiver is not motivated to make changes but who is not actively resistant to change. This would also included a placement in which there is disagreement about making changes or moderate noncompliance with child's treatment recommendations.
- 3 This level indicates a caregiver that is resistant to making any changes necessary to solve present problems. This would included severe noncompliance or disruptive involvement with child's treatment. This level would be used for a caregiver who has signed a 14 day notice.

Caregiver Knowledge of Child. This rating should be based on caregiver's knowledge of the specific strengths of the child and any problems experienced by the child and their ability to understand the rationale for the treatment or management of these problems.

- 0 This level indicates that the present caregiver is fully knowledgeable about the child's psychological strengths and weaknesses, talents and limitations.
- 1 This level indicates that the present caregiver, while being generally knowledgeable about the child, has some mild deficits in knowledge or understanding of either the child's psychological condition of his/her talents, skills and assets.
2. This level indicates that the caregiver placement does not know or understand the child well and that notable deficits exist in the placement's ability to relate to the child's problems and strengths.
- 3 This level indicates that the present caregiver has a significant problem in understanding the child's current condition. The placement is unable to cope with the child given his/her status at the time, not because of the needs of the child, but because the placement personnel do not understand or accept the situation.

Placement Safety

- 0 This level indicates that the present placement is as safe or safer for the child (in his or her present condition) as could be reasonably expected.
- 1 This level indicates that the present placement environment presents some mild risk of continued neglect, exposure to undesirable environments (e.g., drug use, gangs, etc.) but that no immediate risk is present.
- 2 This level indicates that the present placement environment presents moderate levels of risk to the child including such things as the risk of additional neglect or abuse or exposure to individuals who could harm the child.
- 3 This level indicates that the present placement environment presents a significant risk to the well-being of the child. Risk of neglect or abuse is eminent and immediate. Individuals in the environment offer the potential of significantly harming the child.

Community Capacity for WRAP Services. The definition of community includes the specific placement.

- 0 Community demonstrates ability to involve WRAP services (such as respite, home-based services, etc.) To assist in maintaining the child in the placement given the child's current symptomatology, behavior, and risk. Community and placement may be enthusiastic about these services.
- 1 Community demonstrates some ability or potential to involve WRAP services to assist in maintaining the child in the placement. Community and/or placement may not be enthusiastic, but demonstrates a willingness to try to implement service package.
- 2 Community has limited ability to involve WRAP services in maintaining the child in the placement. Community may lack some necessary services, or these services may be of inadequate quality or the placement may be notably ambivalent about maintaining the child in the current placement.
- 3 Community service providers have no capacity to work with placement (or vice versa) to implement WRAP services. This may be due to the absence of service options, motivation on the part of either the placement or community service providers, knowledge and/or skills.

Multi-System Needs

- 0** This level indicates a child who is involved only with the mental health service system or solely with one system. He/she does not have special needs that must be addressed within other service sectors (e.g., special education, criminal justice).
- 1** This level indicates a child who needs to be involved in special services with one other service system outside of the mental health service system. This would include children with serious medical problems, special education needs, criminal justice involvement, or any additional resource use.
- 2** This level indicates a child with multiple service needs being addressed by agencies that are working together towards complementary goals.
- 3** This level indicates a child with multiple service needs. Agencies have competing goals for the child/adolescent or are uninvolved or refuse to be involved.

Childhood Severity of Psychiatric Illness

Name: _____ Date: _____ Agency: _____

| SYMPTOMS: | 0 | 1 | 2 | 3 | U | N/A |
|------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| NEUROPSYCHIATRIC DISTURBANCE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| EMOTIONAL DISTURBANCE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| CONDUCT DISTURBANCE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| OPPOSITIONAL BEHAVIOR | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| IMPULSIVITY | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| CONTEXTUAL CONSISTENCY OF SYMPTOMS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| TEMPORAL CONSISTENCY OF SYMPTOMS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments:

| RISK FACTORS: | 0 | 1 | 2 | 3 | U | N/A |
|-------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| SUICIDE RISK | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| DANGER TO OTHERS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ELOPEMENT RISK | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| CRIME/DELINQUENCY | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| SEXUAL AGGRESSION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments:

| FUNCTIONING: | 0 | 1 | 2 | 3 | U | N/A |
|--------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| SCHOOL DYSFUNCTION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| FAMILY DYSFUNCTION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| PEER DYSFUNCTION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Comments:

| | 0 | 1 | 2 | 3 | U | N/A |
|-----------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| CO-MORBIDITY: | | | | | | |
| ADJUSTMENT TO TRAUMA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| MEDICAL | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| SUBSTANCE ABUSE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| SEVERITY OF AUBSE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| SEXUAL DEVELOPMENT | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| LEARNING/DEVELOPMENTAL DISABILITY | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Comments: | | | | | | |

| | 0 | 1 | 2 | 3 | U | N/A |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| SYSTEM FACTORS: | | | | | | |
| CAREGIVER ABILITY TO PROVIDE SUPERVISION | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| CAREGIVER MOTIVATION FOR CHANGE | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| CAREGIVER KNOWLEDGE OF CHILD | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| PLACEMENT SAFETY | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| COMMUNITY CAPACITY FOR <i>WRAP</i> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| MULTI-SYSTEM NEEDS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Comments: | | | | | | |

To be used with manual dated 1/1/97

Appendix D

Use of Medicaid as an Alternative Funding Source for the Program and Administrative Costs Associated with the Comprehensive Services Act

The House Appropriations and Senate Finance Committees requested JLARC to include as part of its CSA study an examination of the feasibility and associated fiscal implications of expanding Medicaid's Early Periodic Screening and Diagnostic Testing (EPSDT) program to include residential services (see letter attached at the end of this appendix). The analysis includes the fiscal considerations for State and local budgets to serve children under the Comprehensive Services Act (CSA) and non-CSA children who might be eligible for expanded services. This analysis was originally assigned by the 1997 Appropriations Act to the Department of Medical Assistance Services.

The general study findings of the fiscal analysis are as follows:

- The majority (68 percent) of all CSA children are Medicaid eligible.
- The CSA program could immediately save a potential \$4.4 million dollars annually (\$2.7 million in State savings and \$1.6 million in local savings) by more aggressively pursuing Medicaid dollars for inpatient and outpatient mental health services under the current Medicaid State Plan.
- In the future, the CSA program could save a potential \$36.9 million dollars (\$23.1 million in State general fund savings and \$13.8 million in local savings) annually by expanding the Medicaid program to cover costly residential care and therapeutic foster care services. This estimate includes the non-CSA children who are Medicaid eligible.
- Medicaid funds could be used to offset the administrative costs to the localities for the implementation of CSA. The estimated total Medicaid program costs to reimburse localities for assessment and case management services would be \$4.5 million, with over half of these costs paid with federal dollars.
- Since the inception of CSA in fiscal year 1994, the Commonwealth has missed the opportunity to replace an estimated \$160 million of State and local CSA dollars with federal Medicaid dollars.

This appendix provides a more detailed discussion of these findings. The first section discusses how Medicaid funds can be used to defray CSA program costs. The next section briefly outlines some of the administrative issues that must be addressed if Medicaid funds are to be used for this purpose. The final section discusses how localities can be compensated through the use of Medicaid funds to defray some of the administrative costs created with the implementation of CSA.

Medicaid Funds Can Be Used to Substantially Defray CSA Costs to the State and Localities

A key issue for Virginia's CSA program is whether Medicaid should be used to offset the cost of CSA to both the localities and the State. This possibility has been raised because there are Medicaid-eligible CSA children who are receiving CSA-funded services for which the State could receive Medicaid reimbursement through federal funds. The replacement of funding sources could permit redirecting current funds to serve more children and/or to curb the growth of the CSA budget.

Another advantage of using Medicaid funds to cover more CSA services is that the accountability structure of the Medicaid program -- provider charge structures and billing systems, utilization review practices, quality assurance activities, provider standards, common assessment tools and common program eligibility criteria -- become requirements for CSA. The need for improved accountability in the CSA program was documented in JLARC's CSA report.

Based upon an analysis by JLARC staff, since the inception of the CSA program in fiscal year 1994, the Commonwealth has missed the opportunity to replace an estimated \$160 million in State and local dollars with federal dollars. In addition, Medicaid funding could have been used to defray some of the administrative costs faced by the localities for the implementation of CSA. However, because Medicaid comes with federal program requirements, certain actions, such as the recommendations made in this JLARC report on CSA relating to issues of uniformity in assessment, case management, and utilization review, must be implemented in conjunction with any move towards Medicaid funding.

The Link Between Medicaid and Mental Health Services. Medicaid is a joint federal and state program that finances health care for low-income Americans. Within broad federal guidelines, each state establishes its own eligibility standards; determines the type, amount, and duration of services to be provided; sets payment rates; and administers its own program. To help defray the cost of the services funded through Medicaid, the federal government pays a portion of the program's total expenditures for each state. For Virginia, the federal government reimburses the State for 51.45 percent of the payments made under its Medicaid program.

Medicaid is an important source of funding for the treatment of serious mental illness, both long-term and acute. As with all state Medicaid programs, certain services provided by Virginia's program are mandated by the federal government, while others are optional services that Virginia has elected to provide. Virginia's Medicaid State Plan provides a variety of inpatient and outpatient services for the mentally ill which can be provided to children by hospitals, physicians, psychologists, hospital outpatient departments, or Community Service Boards.

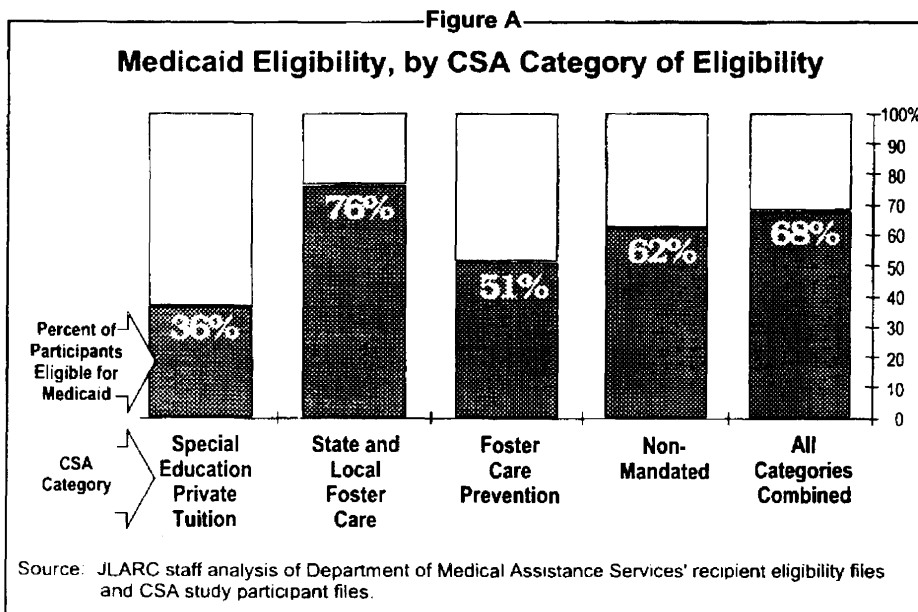
Additionally, Virginia's Medicaid program provides financial support for children through Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. EPSDT screening services refer to those screening and diagnosis services used to determine physical or mental problems for children who are less than 21 years of age.

Use Of Medicaid Funds to Offset the Costs to CSA. The answer to the question of whether this policy change for Medicaid and CSA is a worthwhile pursuit for the State turns on three issues:

- whether a substantial number of children in CSA are Medicaid-eligible;
- whether a sufficient number of these children receive the type of services that would be reimbursable under Medicaid; and
- whether expanding the Medicaid program to pay for the cost of these services would still result in sufficient savings to the State given the additional number of non-CSA children who may qualify for the expanded service.

JLARC's extensive database on the characteristics and service utilization of a sample of CSA children is the Commonwealth's first opportunity to fully address these issues.

The first issue, the proportion of children in CSA who are Medicaid eligible, was addressed by matching Medicaid eligibility data with JLARC's CSA participant database. This analysis found that 68 percent of all CSA children in the study sample were eligible for Medicaid. Figure A presents the Medicaid eligibility for each of the CSA categories of eligibility. Because of the high proportion of CSA children who are Medicaid eligible and the increasing



individual CSA participant costs for services, the use of Medicaid funded services as an alternative funding source becomes a viable option.

JLARC staff addressed the second issue by determining whether Medicaid funds are under-utilized for CSA. This can occur in two ways. First, there may be services that Medicaid currently covers under the State Plan that are not being fully utilized by the localities when accessing services through CSA. For example, inpatient hospitalization or outpatient individual and family psychotherapy services may be funded with Medicaid dollars in lieu of CSA dollars. Second, residential psychiatric care or therapeutic foster care are two additional services that Medicaid could add to the State Plan to qualify for federal match dollars, rather than use all CSA dollars. Exhibit 1 provides a description of these four services.

| <p>Exhibit 1</p> <p>Descriptive Overview of Service Categories</p> |
|---|
| <p><u>Inpatient Mental Health Services:</u> Specialized medical facilities which are designed to treat youths with severe psychiatric disorders and/or a recent onset of risk behaviors, such as children who pose an immediate danger to self or others, potentially including a suicide risk. <i>(Currently covered by Medicaid State Plan).</i></p> |
| <p><u>Outpatient Mental Health Services:</u> (1) Therapeutic Counseling Services: provided in the community by professional counselors and psychologists to address psychological or other mental health related problems observed in the child, (2) Home-Based Services: designed as a form of crisis intervention for children who are at imminent risk of being placed out of the home because of behavior problems or the poor parenting skills of their guardians, and (3) Day Treatment Services: services which offer intensive day support to children and adolescents. <i>(Currently covered by Medicaid State Plan).</i></p> |
| <p><u>Residential Care:</u> Out-of-home placements in therapeutic group homes where youths receive education, counseling, and physical conditioning on-site. <i>(Proposed addition to Medicaid State Plan).</i></p> |
| <p><u>Therapeutic or Specialized Foster Care:</u> Services involving the placement of the youth in an alternative family setting in which at least one of the guardians is specifically trained to work with children who have physical disabilities and/or emotional and behavioral problems. <i>(Proposed addition to Medicaid State Plan).</i></p> |
| <p>Source: JLARC staff analysis of Virginia CSA Fee Directory and Medicaid service definitions.</p> |

Through the use of Medicaid claims data and the JLARC CSA participant database, JLARC staff found that Medicaid is already funding extensive inpatient and outpatient mental health services for CSA children under the current State Plan. In FY 1997, it is estimated that Medicaid paid over \$16.5 million for inpatient psychiatric services and over \$8 million for outpatient mental health services for CSA children. This \$24.5 million is in addition to \$157.5 million in CSA funds expended in FY 1997 on behalf of these children.

In conducting this analysis, JLARC staff focused on children that met the following three criteria:

- Medicaid eligible in FY 1995;
- received one of the four services in FY 1995 which are under review (inpatient mental health services, outpatient mental health services, residential care and/or therapeutic foster care); and
- met potential Medicaid program eligibility criteria for the specific service received.

The estimate of potential savings was developed by first identifying the CSA services received by each child in JLARC staff's study sample that are already included in the Medicaid State Plan but were paid for through CSA. For each of these children, JLARC staff also examined their diagnosed psychiatric behavior and risk. For example, if a child received inpatient psychiatric services and the assessment used by JLARC staff indicated a serious psychiatric disorder, it is likely that Medicaid dollars could have paid for this service in lieu of CSA dollars. As shown in the upper half of Table 1, an additional \$1.5 million for inpatient mental health services and an additional \$7.0 million for outpatient mental services of CSA funds could have potentially been reimbursed through Medicaid. This would have resulted in a potential State and local savings of \$4.4 million.

The second set of savings, shown in the lower half of Table 1, was estimated by evaluating the CSA costs of services that Medicaid does not currently cover in Virginia, but which could be included if the State modified its Medicaid State Plan. Two of the CSA services that can be covered by Medicaid with changes to the State Plan are payment for residential care under EPSDT and therapeutic foster care. Again, this estimate only includes children who received these CSA funded services and who also were assessed to have the risk factors and/or psychiatric symptoms which indicate that they may potentially meet Medicaid's program eligibility criteria. Children who received these services but were assessed and found not to have needed this level of service were excluded.

JLARC's staff analysis estimates that CSA program costs of \$56.2 million paid for residential care and \$20.8 million paid for therapeutic foster care for CSA children in FY 1997 could potentially have been reimbursed through the Medicaid

Table 1

Estimate of CSA Funded Service Costs That Could Be Reimbursed By Medicaid

I. CSA Services Medicaid Currently Has in the State Plan

Inpatient Mental Health Services

No. of CSA Children: 73
 Average Cost of Service: \$21,225
 Total Cost: \$1,549,425

Current Medicaid Usage

Federal Share (0%): \$0
 State Share (62.7%): \$971,489
 Local Share (37.3%): \$577,936

State Savings: \$499,831
 Local Savings: \$297,348

Subtotal of State Savings: \$2,746,612
 Subtotal of Local Savings: \$1,633,949

Proposed Medicaid Usage

Federal Share (51.45% of total cost): \$797,179
 State Share (62.7% of remaining total cost): \$471,858
 Local Share (37.3% of remaining total cost): \$280,588

Outpatient Mental Health Services

No. of CSA Children: 1,305
 Average Cost of Service: \$5,337
 Total Cost: \$6,964,785

Current Medicaid Usage

Federal Share (0%): \$0
 State Share (62.7%): \$4,366,920
 Local Share (37.3%): \$2,597,865

State Savings: \$2,246,780
 Local Savings: \$1,338,801

Proposed Medicaid Usage

Federal Share (51.45% of total cost): \$3,583,382
 State Share (62.7% of remaining total cost): \$2,120,140
 Local Share (37.3% of remaining total cost): \$1,261,263

II. CSA Services for Which Changes Would Be Required in the State Plan

Residential Care

No. of CSA Children: 1,595
 Average Cost of Service: \$35,253
 Total Cost: \$56,228,535

Current Medicaid Usage

Federal Share (0%): \$0
 State Share (62.7%): \$35,255,291
 Local Share (37.3%): \$20,973,244

State Savings: \$18,138,847
 Local Savings: \$10,790,734

Subtotal of State Savings: \$24,865,296
 Subtotal of Local Savings: \$14,792,274

Proposed Medicaid Usage

Federal Share (51.45% of total cost): \$28,929,581
 State Share (62.7% of remaining total cost): \$17,116,444
 Local Share (37.3% of remaining total cost): \$10,182,510

Therapeutic and Specialized Foster Care

No. of CSA Children: 1,305
 Average Cost of Service: \$15,978
 Total Cost: \$20,851,290

Current Medicaid Usage

Federal Share (0%): \$0
 State Share (62.7%): \$13,073,759
 Local Share (37.3%): \$7,777,531

State Savings: \$6,726,449
 Local Savings: \$4,001,540

Proposed Medicaid Usage

Federal Share (51.45% of total cost): \$10,727,989
 State Share (62.7% of remaining total cost): \$6,347,310
 Local Share (37.3% of remaining total cost): \$3,775,991

Gross State Savings: \$27,611,908
Gross Local Savings: \$16,426,223
Gross Total Savings: \$44,038,131

Notes:

The number of children eligible for Medicaid Services is based on FY 1995 CSA participant data and applied to the FY 1997 CSA population of 14,501. The average costs of services are based on FY 1995 costs, as derived by JLARC staff from the CSA participant files. No inflation rate is applied. Potential State and local savings are based upon the FY 1997 Medicaid match rate of 51.45 federal; 48.55 State. The potential State savings is then distributed based upon the average State and local share of CSA expenditures 62.7% State and 37.3% local. Source: JLARC staff analysis of the Department of Medical Assistance Services' MMIS eligibility data, and CSA study participant files.

program. Before accounting for the costs of serving non-CSA children under the expanded Medicaid program, the potential savings shared between the State and the localities for the use of Medicaid funds for just these two services would be \$40 million annually. The savings for all four services (current and proposed) would exceed \$44 million annually.

Some CSA Savings Through Medicaid Are Offset by Non-CSA Children. The savings described above, however, will need to be offset by the number of non-CSA children that may access residential care under an expanded Medicaid program. As requested by the General Assembly in October 1997, JLARC staff expanded the CSA study to include the third issue, which is an analysis of the impact of the non-CSA children on Medicaid expansion of residential care under EPSDT. The General Assembly directed JLARC as part of its study of CSA, to include an assessment of the benefits and disadvantages associated with this expansion of EPSDT, including the costs the State would incur from non-CSA children who might be eligible for expanded services and the fiscal considerations for State and local budgets.

JLARC staff determined that there are two potential groups of children that may be Medicaid eligible, require residential care services, and are not currently being served through CSA. These are the children served through the juvenile court system and those served through the regional mental health centers, known as Community Service Boards (CSBs). Some of these children do receive services under CSA as non-mandated children, but most do not. Therefore, because Medicaid cannot limit the access to residential care under EPSDT only to children in CSA, it is likely that these children would now access this service.

Estimates of the number of additional non-CSA court children that may access residential care under EPSDT were derived from FY 1997 court records of the number of juveniles charged with delinquent acts and/or status offenses. Using past JLARC reports on the juvenile justice system, this figure was then reduced by a number of factors, such as the number of cases that went through the entire court process, the proportion of the children placed in residential care, the proportion that were Medicaid eligible, and the proportion that had severe or acute emotional or psychiatric problems. The steps used to calculate this estimate are outlined in Table 2. The total number of non-CSA court children that may access residential care under EPSDT was estimated to be 94 children at a cost of \$3.3 million a year (51.45 percent or \$1.7 million would be paid with federal dollars. State and local CSA funding sources would have to pick up the balance of \$1.6 million).

Estimates on the second group of non-CSA children, those served by the CSBs, were derived through a review of all Medicaid files on denied admissions for inpatient psychiatric admissions in fiscal year 1995. These files contained all children who sought inpatient psychiatric care under EPSDT, went through the required pre-admission screening by the CSBs, and were denied because they did not meet the inpatient criteria for a severe psychiatric disorder. As shown in Table 2, files were eliminated that were covered in other estimates, which brought the remaining number of children to 65. Based on JLARC staff's review of these

Table 2

**Steps to Calculate Estimate of Number of
Non-CSA, Medicaid-Eligible Population to Receive
Services Under Expanded Medicaid Program**

| Steps to Determine the Number of Non-CSA Children Served Through the Department of Juvenile Justice | | Steps to Determine the Number of Non-CSA Children Served Through the Community Services Boards | |
|---|--|--|-----------------------------|
| *Total number of juveniles charged with a felony, misdemeanor and/or status offense, FY 1997 | 44,092 | Total number of Medicaid denials for inpatient psychiatric care in FY 1995 | 101 |
| **Proportion of these juveniles petitioned to juvenile court | x .95 41,887 | Total number of CSA children eliminated because they were accounted for in another analysis. | -27 74 |
| **Proportion of these juveniles whose cases are formally adjudicated | 41,887 x .90 37,698 | Total number of DJJ children eliminated because they were accounted for in another analysis. | -20 54 |
| ***Total number of these juveniles that receive non-mandated CSA services | -1,450 36,248 | Additional children added based on CSA growth factor of 10.5 percent (FY96) and 7.8 percent (FY97) | +11 65 |
| **Proportion of these juveniles who are placed in residential programs (not neighborhood group homes) | 36,248 x .03 1,087 | | |
| ++Proportion of these juveniles who are Medicaid eligible | 1,087 x .62 674 | | |
| ****Proportion of these juveniles with severe or acute emotional or psychiatric problems | 674 x .14 94 | | |
| Cost of expanding the Medicaid program to the non-CSA population | 94 x \$35,253 = \$3,313,782 | Cost of expanding the Medicaid program to the non-CSA population | 65 x \$35,253 = \$2,291,445 |
| Total Cost of Expanding the Medicaid Program to the Non-CSA Population | 159 children x \$35,253 = \$5,605,227 (\$2,883,889 federal; \$2,721,338 combination of state and local funds) | | |
| Sources: *Department of Juvenile Justice Services and the Fairfax Court Service Unit (FY 1997 data). ** <u>Juvenile Court Processing For Delinquents and Status Offenders</u> , JLARC, 1996. *** <u>Office of Comprehensive Services</u> . ++ <u>Review of the Comprehensive Services Act</u> , JLARC, 1998. **** <u>The Operation and Impact of Juvenile Correction Services</u> , JLARC, 1997 | Sources: Review of Department of Medical Assistance Services files on FY 1995 denied requests for inpatient psychiatric admissions. All denied admissions reviewed met a lower residential level of care criteria. | | |

children's admission files, all of these children would potentially meet Medicaid criteria for residential care. The cost of expanding the Medicaid program to cover residential care for these children was estimated to be \$2.3 million (51.45 percent or \$1.2 million would be paid with federal dollars).

Therefore, the original estimate of the potential State and local savings for services reimbursed by Medicaid was reduced by serving these 159 non-CSA children at a cost of \$5.6 million (see Table 3). Table 4 reflects the revised potential State and local savings. The total potential savings for all four services (current and proposed) that could be reimbursed by Medicaid is over \$41 million in State and local savings.

| Table 3 | | | |
|--|-----|--|-------------|
| CSA Program Costs Associated with Potential Non-CSA Medicaid Eligible Children Who May Receive Residential Care Under the Expansion of Medicaid to Include Residential Care | | | |
| Number of Non-CSA Medicaid Eligible Children | | | |
| Who Could Receive Residential Care: | | 159 | |
| Average Cost of Residential Care: | | \$35,253 | |
| Total Cost: | | \$5,605,227 | |
| <u>Under Current Medicaid Usage</u> | | <u>Under Expanded Medicaid Usage</u> | |
| Federal Share (0%): | \$0 | Federal Share (51.45% of total cost): | \$2,883,889 |
| State Share (0%): | \$0 | State Share (62.7% of total remaining cost): | \$1,706,279 |
| Local Share (0%): | \$0 | Local Share (37.3% of total remaining cost): | \$1,015,059 |
| State Cost of Medicaid Expansion: (1,706,279) | | | |
| Local Cost of Medicaid Expansion: (1,015,059) | | | |
| Notes | | | |
| <ul style="list-style-type: none"> The number of children eligible for Medicaid Services is based on FY 1995 CSA participant data and applied to the FY 1997 CSA population of 14,501. The average costs of services are based on FY 1995 costs, as derived by JLARC staff from the CSA participant files. No inflation rate is applied. Potential State and local savings are based upon the FY 1997 Medicaid match rate of 51.45 federal; 48.55 State. The potential State savings is then distributed based upon the average State and local share of CSA expenditures: 62.7% State and 37.3% local. | | | |
| <p>Source: JLARC staff analysis of the Department of Medical Assistance Services' MMIS eligibility data, DMAS' denied requests for inpatient psychiatric care, Department of Juvenile Justice and Fairfax Court Service Unit juvenile court statistics, data contained in <u>Juvenile Court Processing for Delinquents and Status Offenders</u> (JLARC 1996), and in <u>The Operation and Impact of Juvenile Correction Services</u> (JLARC 1997), and data obtained through CSA participant file reviews for the <u>Review of the Comprehensive Services Act</u> (JLARC 1998).</p> | | | |

Table 4
Net Fiscal Effect of Fully Utilizing Medicaid for
Inpatient and Outpatient Mental Health Services,
and Expanding the State Plan to Include
Residential Care and Therapeutic and Specialized Foster Care

Immediate CSA Savings of Fully Utilizing Medicaid for Inpatient and Outpatient Mental Health Services

| | |
|----------------|-------------|
| State Savings: | \$2,746,612 |
| Local Savings: | \$1,633,949 |

Total Immediate Savings: \$4,380,561

Future Yearly CSA Savings through the Expansion of Medicaid to
Include Residential Care and Therapeutic and Specialized Foster Care

| | |
|-----------------------------------|----------------------------------|
| Gross State Savings: \$24,865,296 | Gross State Costs: (\$1,706,279) |
| Gross Local Savings: \$14,792,274 | Gross Local Costs: (\$1,015,059) |
| Gross Total Savings: \$39,657,570 | Gross Total Costs: (\$2,721,338) |

Net Future Savings: \$36,936,232

Net CSA Program Savings Per Year After Medicaid Expansion: \$41,316,793

Notes

- The number of children eligible for Medicaid Services is based on FY95 participant data and applied to the FY97 CSA population of 14501.
- The average costs of services are based on FY95 costs. No inflation rate is applied.
- Potential State and local savings are based upon the FY97 Medicaid match rate of 51.45 federal; 48.55 State. The potential State savings is then distributed based upon the average State and local share of CSA expenditures. 62.7% State and 37.3% local.

Source JLARC staff analysis of the Department of Medical Assistance Services' MMIS eligibility data, DMAS' denied requests for inpatient psychiatric care, Department of Juvenile Justice and Fairfax Court Service Unit juvenile court statistics, data contained in Juvenile Court Processing for Delinquents and Status Offenders (JLARC 1996), and in The Operation and Impact of Juvenile Correction Services (JLARC 1997), and data obtained through CSA participant file reviews for the Review of the Comprehensive Services Act (JLARC 1998)

Table 5 illustrates the cost comparison for a typical CSA child receiving residential care for a year under the current funding mechanism and the proposed Medicaid funding mechanism. As shown, under the proposed Medicaid funding, the State and the locality together can save \$51,450 for a child that now costs \$100,000 a year.

Based on JLARC staff's findings and the substantial savings projected to the State and the localities, the policy change to seek Medicaid funding appears to be a worthwhile pursuit. However, there are advantages and disadvantages to this approach and the timetable for implementation of these changes must be considered.

| Table 5 | | | | |
|--|---|----------------------|--------------------|--------------------|
| Cost Comparison for a CSA Child in Residential Care Under Current Funding and Medicaid Funding | | | | |
| <u>Source of Funding</u> | <u>Cost of One Year in Residential Care for One Child</u> | <u>Federal Share</u> | <u>State Share</u> | <u>Local Share</u> |
| Current CSA Funding | \$100,000 | \$0 | \$62,700 | \$37,300 |
| Proposed Medicaid Funding | \$100,000 | \$51,450 | \$30,441 | \$18,109 |
| Potential State and Local Savings Under Medicaid Funding Proposal | | | \$32,259 | \$19,191 |
| Note: The potential State and local savings were based on the current State and local share of CSA expenditures: 62.7 percent State and 37.3 percent local. | | | | |

Implementation Issues for the Use of Medicaid Funds

A 1991 legislative study first discussed in detail the use of Medicaid funds to provide mental health services to “at-risk” children and their families. Since that time, there has been reluctance at both the State and local level to proceed. In a 1997 presentation to the General Assembly, the Department of Medical Assistance Services (DMAS) cited three major issues regarding the expansion of Medicaid services to cover services now paid through CSA:

- Medicaid funding brings with it stringent federal requirements. For example, comparability requirements mandate that any covered service must be available to all eligible children, not just those served by CSA.
- Adequate funding with controlled growth must match any mandate to expand Medicaid services. If new services are added, State matching funds must be available. There must be a careful evaluation of where this match will come from to ensure that there is not an unintended incentive to increase residential placement as a way to avoid the expenditure of local funds and shift the cost back to the State.
- Utilization management for quality of care is essential. There must be aggressive monitoring of the providers to ensure that the children receive

intensive treatment and are returned to their homes and communities as soon as possible.

In addition, DMAS recently responded to the JLARC study of CSA and provided additional comments on the need for a more cohesive State administrative structure and consistent services and reporting statewide prior to recommending a greater role for Medicaid in funding CSA. The necessary changes are found in the JLARC staff recommendations for the CSA program.

The localities have been reluctant to use Medicaid-funded services because of the administrative and program changes that go along with the use of federal dollars. These administrative changes, which require increased accountability for services provided and dollars spent on behalf of CSA children, may be seen as contrary to the original intent of the CSA program – which is to afford the localities flexibility in the design of their CSA programs. Many see the move to Medicaid funding as imposing a medical model on the CSA program. Another issue for localities concerns who will be able to authorize Medicaid services and how the match for Medicaid dollars will be managed.

The cost savings generated to the State and localities, and the program accountability that accompanies the use of Medicaid funds, should outweigh any disadvantages cited by localities. The advantages of the use of Medicaid funds would also improve problems cited throughout the JLARC report with the current administration of the CSA program, including:

- uniform assessment and program criteria;
- comprehensive case management services, including the development of care plan, formal monitoring of the care plan, and discharge planning;
- provider standards;
- utilization management for quality of care;
- charge structures and accounting procedures; and
- controlling fees paid to providers.

The issue of who pays the match dollars for the use of federal dollars to pay for CSA services is important to both the State and the localities. The Department of Medical Assistance Services suggests that the match rate for residential care services should not be paid entirely with State funds because there may be an unintended incentive on the part of the localities to place children in residential care. The localities are concerned that match requirements may increase local costs for CSA. One option is for the State and local match requirements to stay the same as the current CSA program, whereby the State pays approximately 63 percent of the costs not reimbursed with federal Medicaid dollars and the localities pay approximately 37 percent. Then both the State and localities

will be sharing the cost of approximately 50 cents of each service dollar. Other options which could be considered by the General Assembly are to reduce the locality match rate for residential services or eliminate it all together.

Another issue of concern to the State and localities is the time frame for implementing the changes in order to move toward Medicaid funding of CSA services. The State and localities could achieve the \$4.4 million savings immediately through the aggressive pursuit of Medicaid funding for services that are in the current State Plan, but which CSA is currently funding with all State and local dollars.

It is important to recognize that the State and localities could not realize the additional \$36.9 million of potential savings immediately. The shift to Medicaid funding for residential care and therapeutic foster care for CSA children will need to be phased in over time in order to address the major issues cited in this memorandum. While potential providers should be willing to accept Medicaid payment for services if it becomes the major funding source for their operations, many providers may not currently meet the federal provider standards.

Local Administrative Costs of JLARC's Recommendations

With CSA, interagency collaboration was viewed as a vehicle to reduce duplication in the processes used by localities to serve at-risk children. Many believed that by eliminating the duplication of services, local agencies would be able to free up agency staff resources and redirect these resources to address administrative costs associated with the CSA program implementation. Also, the State was to assist localities in CSA administration by providing a separate pool of funds for administrative activities. This funding would be based on a percentage of the locality's CSA pool allocation and limited to an amount (subject to a local match) of not less than \$5,000 and not more than \$25,000.

Many local CSA participants have informed JLARC staff that State administrative funding has not sufficiently covered the administrative costs associated with implementing CSA. Also, as CSA caseloads have increased, local agencies contend that they have not been able to adequately address the fiscal, accounting, and coordinating activities needed to implement CSA. Local CSA participants added that in many cases, in order to implement the program, the duties of existing staff had to be expanded to include these new administrative responsibilities. In other cases, newly created positions were established, but State administrative funds only partially covered the costs of these positions. In a few cases, localities pooled administrative funds in order to hire staff to coordinate CSA activities, but the administrative funding for these collaborative efforts was still limited.

Additional concerns have been raised over the potential impact of JLARC staff's recommendations to improve the local operation of CSA. There are opportunities, however, to reduce administrative costs to localities through Medicaid reimbursements.

Use of Medicaid Funds to Offset the Administrative Costs of CSA.

The Virginia Medicaid program currently uses Medicaid administrative and service dollars to fund assessment and case management services for special populations such as the elderly, the disabled, the mentally ill and the mentally retarded. Table 6 provides an estimate of the Medicaid program costs of expanding Medicaid payment for assessment and case management services provided to CSA children. The Medicaid program could fund, out of its administrative funds, assessments for all CSA children seeking CSA treatment services. Assessment costs can be utilized for all CSA children, even those that are not currently Medicaid eligible, if they are anticipated to become Medicaid eligible and are seeking potential Medicaid-funded services, such as inpatient mental health, residential services, or therapeutic foster care. Medicaid payment for assessments would ensure that children have equal access to care across the Commonwealth and that the children's services matched their identified needs. The cost of Medicaid-funded assessment services for CSA children would be approximately \$1.0 million (approximately \$500,000 of which would be paid with federal dollars).

Medicaid payment for targeted case management services would be limited to Medicaid eligible CSA children. Because 68 percent of CSA children are Medicaid eligible, payment for these services would cover the majority of the children. The non-Medicaid CSA children would continue to receive similar case management activities. As shown in Table 6, based upon JLARC CSA participant data and current Medicaid fees for case management services, it is estimated that Medicaid funding for targeted case management services would cost \$3.5 million (\$1.8 million of which would be paid in federal dollars).

If Medicaid funds are used to defray some of the administrative costs of CSA, then it appears that the cost to the Medicaid program would be about \$4.5 million. Of this amount, over half would be paid with federal dollars. Since assessment and case management services are reimbursed through Medicaid on a per child basis and not through grant allocation formulas to the localities, localities would bill the Medicaid program directly for these costs. Therefore, in order to proceed with this option, the State dollars used to match these administrative costs will need to be placed in the Medicaid budget. However, it is important to note that the use of Medicaid funding for these purposes cannot be implemented prior to changes to the Medicaid State Plan and the implementation of the JLARC report recommendations pertaining to common procedures for assessment and case management activities.

Table 6**Use of Medicaid Funds to Defray
Administrative Costs of CSA**

| Type of Medicaid Funded Service | Number of Children Served | Program Cost | Federal Share | State Share |
|--|--|-------------------------|--------------------------|--------------------|
| Assessment | 9,571 | \$ 957,100 | \$ 492,428 | \$ 464,672 |
| Targeted Case Management Services | 6,508 | \$3,524,121 | \$1,813,160 | \$1,710,961 |
| Total Potential Costs of Expanding Medicaid to Cover CSA Administrative Costs | | \$4,481,221 | \$2,305,588 | \$2,175,633 |

Notes: All analysis based on 14,501 FY 1997 CSA children.

- Assessment costs exclude 34 percent of CSA children that receive only room and board under foster care and not seeking any treatment services. The Medicaid payment rate is based upon \$100/assessment which is the rate used for the Medicaid Nursing Home Pre-Admission Screening Program. Assessment costs can be utilized for all CSA children, even those that are not Medicaid eligible, if they are seeking potential Medicaid funded inpatient mental health or residential services.
- Medicaid targeted case management services exclude the 34 percent of CSA children that receive only foster care and also excludes an additional 32 percent of children that are not Medicaid eligible. The Medicaid payment rate is based upon CSA length of stay information, typical case management activities, and the Medicaid case management rates for Consumer-Directed Personal Care Services (\$161/\$209 for the initial comprehensive visit; \$50/\$65 for routine onsite at 30-90 days; \$80/\$105 for formal reassessments every 6 months. The latter rate is the Northern Virginia differential which was applied to 25 percent of the cases.



Commonwealth of Virginia

GENERAL ASSEMBLY
RICHMOND

October 24, 1997

Mr. Philip A. Leone
Director, Joint Legislative Audit and Review Commission
11th Floor, General Assembly Building
Richmond, Virginia 23219

Dear Phil:

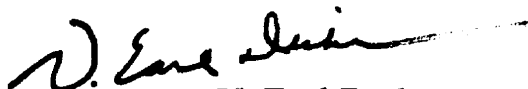
During our review of the Comprehensive Services Act (CSA) last session, the House Appropriations and Senate Finance Committees discussed the possibility of expanding Medicaid's Early Periodic Screening and Diagnostic Testing (EPSDT) program to include residential services. We did not reach a conclusion because the issue was very complex, and no data existed to help the Committees determine if it would be prudent for the State to use EPSDT funding for residential services.

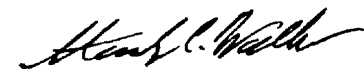
We feel that data the Joint Legislative Audit and Review Commission (JLARC) staff are collecting as part of its review of CSA would be helpful to this discussion. Specifically, we feel that JLARC staff could provide the Committees with a realistic assessment of the benefits and disadvantages of expanding EPSDT, including an estimate of the cost the State would incur from non-CSA children who might be eligible for expanded services.

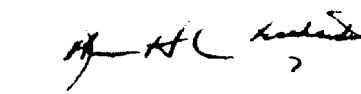
Therefore, as part of JLARC's study of CSA, we ask that you include analysis of the potential for expanding EPSDT, including fiscal considerations for State and local budgets. We understand that this request could cause some delay in your report date, but feel that it is important to make the report as comprehensive as possible.

Thank you for your attention to our request.

Sincerely,


V. Earl Dickinson


Stanley C. Walker


John H. Chichester

Appendix E

Agency Responses

As part of an extensive data validation process, the major State agencies involved in a JLARC assessment effort are given an opportunity to comment on an exposure draft of the report. Appropriate technical corrections resulting from the written comments have been made in this version of the report.

This appendix contains responses to the main report from the following:

- Secretary of Health and Human Resources
- Office of Comprehensive Services
- Department of Medical Assistance Services
- Department of Planning and Budget

In addition, this appendix contains:

- Response of the Office of Comprehensive Services after its review of the Medicaid assessment (Appendix D)



COMMONWEALTH of VIRGINIA

Office of the Governor

George Allen
Governor

Robert C. Metcalf
Secretary of Health and Human Resources

November 14, 1997

Mr. Philip A. Leone, Director
Joint Legislative and Review Commission
Suite 1100, General Assembly Building
Capitol Square
Richmond, Virginia 23219

Dear Mr. Leone:

Enclosed please find a letter from Alan Saunders, Director, Comprehensive Services for Youth and Families (CSA). In addition to my statements, Mr. Saunder's letter constitutes the response of the Office of the Secretary of Health and Human Resources.

During the Allen Administration, significant effort has been made to address rising costs and more effectively manage a growing program. Along with Mr. Saunders, I too have concerns with the fiscal implications of Recommendation 1. The costs of this program have escalated and only with utilization and review will both state and local levels of government be able to "get a handle" on the rising costs of this program. These rising costs are associated with only those who are currently eligible for CSA services. Any increase to that population, prior to proper utilization and review fiscal controls, seems ill advised.

Thank you for your interest in CSA and the work done by the review team. If you have any questions, please do not hesitate to contact Jeff Wilson on my staff at 786-7765.

Sincerely,

A handwritten signature in cursive script, appearing to read "Robert C. Metcalf".

Robert C. Metcalf



COMMONWEALTH of VIRGINIA
COMPREHENSIVE SERVICES FOR YOUTH AND FAMILIES

November 14, 1997

Mr. Philip A. Leone, Director
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building
Capitol Square
Richmond, Virginia 23219

Dear Mr. Leone:

Thank you for the opportunity to review and comment on the exposure draft of your "Review of the Comprehensive Services Act". I also appreciate the opportunity to meet with you and your staff to provide you with our suggestions for some technical changes to the report. This letter will provide you with the Office of Comprehensive Service's (OCS) initial response to the report's recommendations.

Let me begin by saying I am encouraged that, according to your survey findings, 70 percent of the parents or guardians of children served by the CSA indicated the services provided improved their child's behavior and the desired outcomes were occurring. Given the level of family dysfunction local governments are often addressing through the Comprehensive Services Act (CSA), this is a promising "success". Of course, I am also pleased your findings substantiate that CSA's intended multi agency approach in providing services is beneficial. With the growth in the number seeking services, it is frightening to think of where we would be had the Commonwealth not implemented the CSA.

Though the CSA is still a very young program, it has accomplished a great deal. This is most evident in the way many local staff are working together to address problems. By this account and many others, the program's implementation phase was a success. Even though we are now in the early operational phase of the program, all agree refinements are essential if we are going to achieve this program's potential. This would be true with any massive program change like the CSA. A number of refinements have already been made including reporting enhancements and the expansion of the OCS staffing level to include a compliance element. Others are currently in process including the implementation of a utilization management system that complies with the Appropriation Act requirements. Still I agree, others are needed. The report identified a number of refinements that, when made, will go further to improve the CSA at both the state and local level.

Some of the Commission's recommendations, if adopted, will increase the program's cost, a cost that is already a concern and one which must ultimately be borne by the taxpayers. The recommendation to expand eligibility for sum sufficiency funding is one such recommendation. While a number of localities are reportedly classifying certain non-mandated participants as mandated, it will significantly further increase the program's cost. Many more children will become mandated and the state as well as local governments will have no choice but to provide CSA funded services. As the legislature moves forward in considering this recommendation, my hope is we can revisit the concept of parental co-payment, currently a local option within the CSA statute, to offset taxpayer costs.

The recommendation to return the family foster care portion of the program to the Department of Social Services appears to be appropriate, on the surface. However, a number of these children move back and forth, some quite often, between the more intense CSA services and family foster care. Concerns about how to accomplish this movement in an orderly fashion surfaced during the original deliberations leading up to what has become the CSA. Due to the likely complications that would occur such as "who pays disputes," this type of separation of funding was dismissed. As the legislature considers this recommendation, attention must be paid to this issue to ensure we have the least disruptive process with these transfers.

I agree with the recommendation requiring all CSA funded cases to be reviewed by multi-agency teams, but I am concerned this will increase local administrative costs. Should the family foster care program, referenced above, remain within the CSA however, the legislature should consider an exemption for the true family foster cases. Local governments have often expressed concern about this approach for these types of cases. They claim the cost resulting from the administrative burden of a multi agency approach would far exceed any benefit possible for these less complex cases. If only the basic, State Board of Social Services established maintenance payments are involved, little is likely to be gained from the multi-agency reviews.

I agree with the several recommendations to require utilization management technology be included in the CSA system. A uniform assessment process as well as uniform case management and case review standards should all be a part of this system. We should also have access to the data necessary to not only support a statewide utilization management system, but to ensure it is achieving the intended results. Due to the volume of this data, automation is critical. Existing or soon to be online systems should be utilized to minimize the duplication of data input problems that would occur with yet another separate system for CSA. The State Executive Council, as you know, is actively taking steps to include utilization management technology in the CSA. The current appropriation language, however, does not allow the imposition of the more structured, single statewide approach your recommendations suggest.

Philip A. Leone
November 14, 1997
Page 3

Finally, I agree with the recommendation to reorganize the state level management structure. The Office of Comprehensive Services should be recognized as the administrative component responsible for the Comprehensive Services Act. As the administrative component, the Office should have the appropriate authority, staff, and organizational placement necessary to carry out those responsibilities. Any reorganization should also include an examination of the current placement of CSA's financial functions within the Department of Education apart from the Office of Comprehensive Services.

Before closing, I would also like to thank your staff for their professionalism in collecting data and compiling this report. Quite often during your staff's visits with local governments gathering information, local staff would call to express their impressions about your staff and the work they were doing. In every case, localities were complimentary, often remarking about the professional approach your staff took as they went about their work. The same was true as my staff and I interacted with the staff during the study. Please convey my thanks to each member of your CSA review team.

Sincerely,

A handwritten signature in black ink, appearing to read "Alan G. Saunders", written over a horizontal line.

Alan G. Saunders
Director



11 1497

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

JOSEPH M. TEEFEY
DIRECTOR

November 12, 1997

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804 786-7933
804 225-4512 (Fax)
800 343-0634 (TDD)

Mr. Philip A. Leone
Director
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building
Capitol Square
Richmond, Virginia 23219

Dear Mr. Leone:

Thank you for the opportunity to review the exposure draft of your report, Review of the Comprehensive Services Act. This comprehensive report will be of great assistance to the General Assembly in reviewing the program and planning for the future. I have confined my comments to the Medicaid portions of the report.

Issues

1. The report recommends a much greater role for Medicaid in funding Comprehensive Services Act (CSA) administrative costs and services like children's psychiatric residential services. The bulk of the portions of the report dealing with Medicaid are still in progress, but if Medicaid is to play a much larger role, the lack of a cohesive State administrative structure for CSA will put the Department of Medical Assistance Services (DMAS) in a very difficult position. The great amount of local control of CSA will result in an adversarial relationship between DMAS and local governments. DMAS is a State agency. Medicaid services must be comparable among eligible children and must be consistent statewide. The report asserts that this is a strength which will ensure better management, consistency of services and reporting. However, due to the variability of service programs and administrative practices among localities, opportunities for conflicting expectations of Medicaid will be rife. Local governments will view Medicaid requirements as disruptive to their flexibility and

autonomy. This is not unlike the dissatisfaction expressed by Community Service Boards about Medicaid requirements for community mental health, mental retardation, and substance abuse services reimbursement.

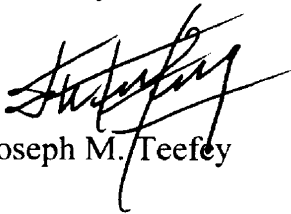
2. While it is feasible for Medicaid to pay for components of the CSA administration through targeted case management and assessment, the requirements must be set forth in the State Plan for Medical Assistance. It is not certain that all localities can or want to conform to one statewide standard. The report should clarify that all localities must participate and should clarify what role, if any, there will be for the private sector provider.
3. Medicaid rules are complex and somewhat inflexible. With Medicaid funding comes federal mandates and standards. Service funds are paid only after services are rendered. Documentation of records must clearly verify all services for which bills are submitted. Many localities do not have the proper service and management records to meet Medicaid requirements and do not have billing structures in place in order to submit claims. Localities will require a great deal of technical assistance in order to make the shift from grant funds to a revenue-based funding system.
4. During the past year, DMAS has been engaged in a cooperative effort with the Office of Comprehensive Services to amend DMAS's contract for utilization management to include utilization of CSA residential services. The process has been protracted and hard to define because of the lack of definition and local control in CSA. After months of negotiation, the contract is still not signed. Although I am convinced that this project will provide positive feedback on placements, the lack of authority at the State level has hampered efforts to complete the project. I support any reforms which will provide better State oversight and more effective administration of CSA before Medicaid becomes more directly involved in the program.
5. One continuing concern is the lack of accountability of the State Executive Council. Although your report stresses the need to strengthen the State Executive Council, the report does not recommend any accountability requirements. In

Mr. Philip Leone
November 12, 1997
Page Three

addition, if CSA is placed at the Department of Mental Health, Mental Retardation and Substance Abuse Services, what incentive will there be for the other agencies to view CSA as a priority?

We look forward to reviewing the remaining Medicaid portions of the report. Thank you and your staff for their assistance in looking closely at the Medicaid issues.

Sincerely,



Joseph M. Teefey

JMT/aec

03j\cook\project\csa\leone.doc



COMMONWEALTH of VIRGINIA

Robert W. Lauterberg
Director

Department of Planning and Budget

200 N. Ninth St., Room 418
Richmond, VA 23219

November 14, 1997

Mr. Philip A. Leone,
Director, Joint legislative Audit and Review Commission
Suite 1100
General Assembly Building
Capitol Square
Richmond, Virginia 23219

Dear Mr. Leone:

Thank you for the opportunity to review JLARC's exposure draft report on the Comprehensive Services Act. I will not respond to the programmatic aspects of the report's recommendations, assuming that such considerations will be addressed by the parties charged with implementing the Act.

However, I do take exception to Recommendation (1) on page sixty-four of the study which calls for consideration of sum sufficient funding for non-mandated cases. This recommendation is counter to current policies governing sum sufficient accounts and, undoubtedly, will further increase program costs.

The recent practice on sum sufficient funding has been to limit these authorizations to instances where spending adjustments are linked to specific revenue collections (distribution of sales tax collections to localities), to legal considerations (debt service payments), to separation of power issues (the enactment of laws by the General Assembly), or to uncontrollable and non-predictable events such as Acts of God (Governor's natural disaster declarations). We have not used sum sufficient appropriations as a way to facilitate services, notwithstanding the fact that sometimes there is a great deal of uncertainty surrounding budgeted amounts. For example, Medicaid and welfare payments as well as the expenses of the courts are all budgeted on a fixed sum basis.

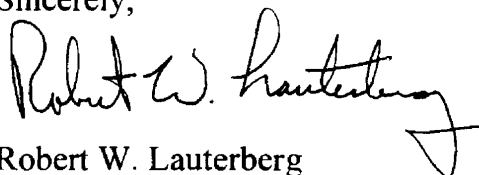
The issue really relates to fiscal discipline. We routinely call on the directors of our agencies and their program managers to budget expenses as accurately as possible and to make every effort to stay within appropriated levels. This practice promotes the type of

fiscal integrity and truth in budgeting for which Virginia receives superior rankings from many sources.

I am of the opinion that we should not alter our course for programmatic convenience or expediency. While I recognize that we face a difficult situation when some children in need of services are classified as "mandated caseload" and others are not, I believe that we would be better served by addressing this discrepancy through efforts to increase flexibility in service delivery and eligibility determination rather than cede fiscal control.

Accordingly, I hope that you will reconsider this recommendation.

Sincerely,

A handwritten signature in black ink that reads "Robert W. Lauterberg". The signature is written in a cursive style with a large, stylized initial 'R' and a long, sweeping tail that extends to the right.

Robert W. Lauterberg

mtb F:\mtb\JLARC.doc

cc: The Honorable Ronald L. Tillett



COMMONWEALTH of VIRGINIA
COMPREHENSIVE SERVICES FOR YOUTH AND FAMILIES

December 17, 1997

7 0 2 9 7

Mr. Philip A. Leone, Director
Joint Legislative Audit and Review Committee
Suite 1100, General Assembly Building
Capitol Square
Richmond, Virginia 23119

Philip
Dear Mr. Leone:

I am writing to express my appreciation for the opportunity to review and attend a briefing on the initial draft of your report on the "Use of Medicaid as an Alternative Funding Source for the Program and Administrative Costs Associated with the Comprehensive Services Act". As always, I commend your staff on their ability to assemble and consolidate information in a very short time span.

Our office will be reserving comment on the content of the report until staff has had time to more fully review the document. As your staff has pointed out, the document contains recommendations that will have substantial impact on the way the state and localities administer and fund services. I am pleased that you mentioned the necessity of providing training and technical assistance and of recognizing that implementation, if approved, must be phased in over time.

As I have stated previously, I believe your report has validated the need for our program and the success of its implementation phase. As we move forward with review and possible modifications, our office will be in the unique position of working with local and state governments as well as providers. We look forward to the upcoming challenges and to assuring that eligible children and their families are served in the most efficient, effective and appropriate manner.

Sincerely,

A handwritten signature in cursive script, appearing to read "Alan G. Saunders".

Alan G. Saunders
Director

JLARC Staff

DIRECTOR: PHILIP A. LEONE
DEPUTY DIRECTOR: R. KIRK JONAS

DIVISION I CHIEF: GLEN S. TITTERMARY
● *DIVISION II CHIEF:* ROBERT B. ROTZ

SECTION MANAGERS:

PATRICIA S. BISHOP, FISCAL AND ADMINISTRATIVE SERVICES

JOHN W. LONG, PUBLICATIONS AND GRAPHICS

GREGORY J. REST, RESEARCH METHODS

PROJECT TEAM LEADERS:

CRAIG M. BURNS

LINDA BACON FORD

HAROLD E. GREER, III

JOSEPH J. HILBERT

● WAYNE M. TURNAGE

PROJECT TEAM STAFF:

EMILY J. BIKOFSKY

● CYNTHIA A. BOWLING

● STEVEN E. FORD

DEBORAH MOORE GARDNER

JACK M. JONES

● MARCUS D. JONES

WAYNE A. JONES

APRIL R. KEES

MELISSA L. KING

ERIC H. MESSICK

ROSS J. SEGEL

E. KIM SNEAD

PAUL VAN LENTEN

● ROWENA P. ZIMMERMANN

ADMINISTRATIVE AND RESEARCH SUPPORT STAFF:

JOAN M. IRBY

BETSY M. JACKSON

BECKY C. TORRENCE

AMANDA J. SMITH, INTERN

● *Indicates staff with primary assignment to this project*

FORMER JLARC STAFF CONTRIBUTING TO THIS PROJECT:

ERIC P. ROLLINS

Recent JLARC Reports

Review of the Virginia Retirement System, January 1994
The Virginia Retirement System's Investment in the RF&P Corporation, January 1994
Review of the State's Group Life Insurance Program for Public Employees, January 1994
Interim Report: Review of the Involuntary Civil Commitment Process, January 1994
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